DR. S. SONKEN

MEDICAID

1977-1981

Major Program Issues

REPORTS
RA
412
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M43
1975

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL AND REHABILITATION SERVICE
Medical Services Administration

July 1975

RA
412.4
.M43
1975

MEDICAID, 1977 - 1981

Summary of Major Program Issues

Medicaid Issues to be Discussed at the Secretary's Conference on Planning Health Financing Programs

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   - Fraud and Abuse

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Summary of Major Program Issues

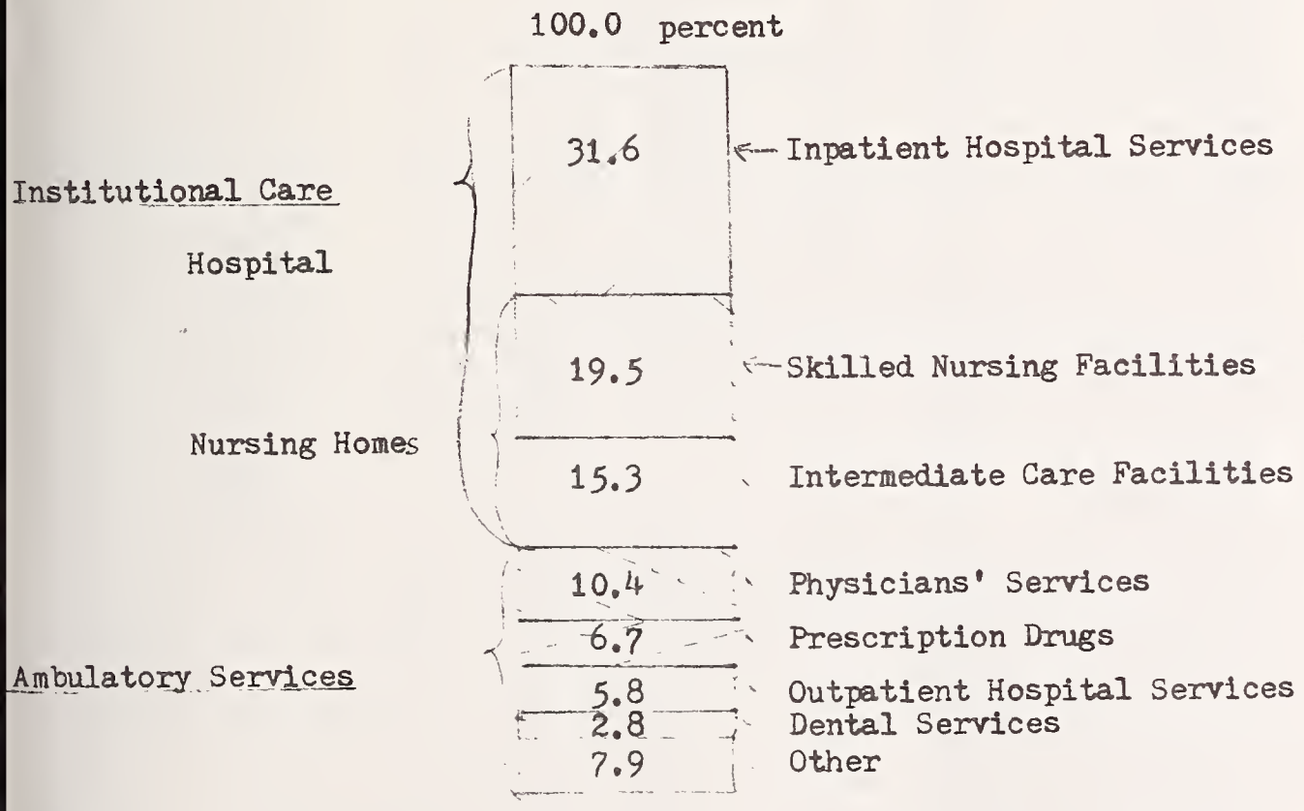
MEDICAID, 1977-1981

Ten years ago, the Medicaid program was established as a Federal/State partnership to finance medical assistance to certain low income people. In these ten years, over fifty billion dollars have been spent, about one in every five Americans has received some medical care through the program and about one out of every fifty Americans has received some income through rendering medical care to Medicaid recipients.

Current Status

The 53 Medicaid programs currently provide medical assistance for about 25 million needy people at costs of almost eight billion Federal dollars and just under seven billion State and Local dollars. The Federal share of the payments to medical vendors averages about 55 percent and varies from 50 to 83 percent, depending upon the per capita income in the State. The average Medicaid AFDC family receives about $950 a year in medical assistance; some States spend less than $450 a year in medical vendor payments for an AFDC family, whereas others spend considerably more than $1,200. (See Tables 1 and 1A)

Chart 1
Medicaid Medical Vendor Payments,
by Services, FY 1975



Source: SRS/OA/FM/OA25, May 1975

SRS/MSA/OC/LR
July 14,1975

Average Medicaid Payment for Recipients
of AFDC Cash Assistance, CY 1974

	Families	Children	Adults		
Alabama	560	90	390		
Alaska					
Arizona	-	-	-		
Arkansas	440	80	270		
California	1,090	240	470		
Colorado *	-	-	-		
Connecticut	780	170	430		
Delaware	660	120	410		
Dist. of Col.	1,280	260	670		
Florida	470	90	300		
Georgia	720	120	530		
Guam	340	40	240		
Hawaii	810	170	410		
Idaho	900	140	620		
Illinois	1,380	280	620		
Indiana	830	180	490		
Iowa	890	210	430		
Kansas	990	180	750		
Kentucky	510	90	320		
Louisiana	450	80	270		
Maine	860	150	490		
Maryland	860	190	470		
Massachusetts	1,130	350	330		
Michigan	1,270	220	790		
Minnesota	1,070	220	720		
Mississippi	250	60	120		
Missouri	380	80	240		
Montana	920	190	630		
Nebraska	830	170	500		
Nevada	1,190	190	1,000		
New Hampshire	790	140	500		
New Jersey	1,090	270	420		
New Mexico	700	140	410		
New York	1,730	500	490		
North Carolina	530	80	450		
North Dakota	860	170	590		
Ohio	1,000	180	600		
Oklahoma	580	170	190		
Oregon	510	100	320		
Pennsylvania	760	140	370		
Puerto Rico	190	40	20		
Rhode Island	940	180	520		
South Carolina	560	80	410		
South Dakota	540	100	360		
Tennessee	440	90	280		
Texas	620	130	540		
Utah	760	180	400		
Vermont	1,060	200	550		
Virgin Islands	280	20	80		
Virginia	800	160	480		
Washington	780	180	400		
West Virginia	790	160	360		
Wisconsin	1,050	300	470		
Wyoming	480	90	350		
U.S.	950	210	460		

Source: NCSS A-2 and B-1 Reports
* No data reported

DHEW/SRC/MSA/DPPE
June 26, 1975

Table 1A

Medicaid Expenditures for AFDC Cash Assistance Recipients,
Number of Cash Assistance Recipients, Averages, Calendar Year 1974

Recipients of Cash Assistance Under AFDC	Average Monthly Number of Recipients* of AFDC	Annual Medicaid Expenditures** for AFDC Cash Assistance Recipients	Average Medicaid Payment for Recipients of AFDC Cash Assistance
Children	7,750,017	$1,646,964,190	$213
Adults	3,024,405	1,391,715,128	460
Families***	3,198,293	3,038,679,318	950
All AFDC Cash Recipients	10,774,422	3,038,679,318	282

Source: *NCSS A-2 Reports for 12 Months, January - December 1974
**NCSS B-1 Reports for 12 Months, January - December 1974
***Average size of AFDC families: 3.4, including .9 Adults and 2.4 Children

DHEW/SRS/MSA/DPPE
June 26, 1975

Of the 25 million Medicaid recipients, some 18 million use physician services; 16 million, prescription drugs; four million, dental services; over four million, inpatient hospital services; and over one and a half million are in skilled nursing facilities or intermediate care facilities. (See Table 2) Almost two-thirds of all Medicaid recipients are females.

Almost half of the Medicaid recipients are individuals under 21 years of age, about a sixth are over 65, less than one-tenth are blind or disabled, and the remaining one-fourth are AFDC parents, essential spouses and the like. (See Table 3) Almost three-fourths of Medicaid recipients also receive some cash assistance under the welfare programs, but just over half of the Medicaid expenditures are for this categorically needy group. (Table 4)

Table 2

Distribution of Medicaid Recipients, by service, FY1975

Total	25,000,000
Inpatient hospitals	4,436,000
Skilled nursing facilities	935,000
Intermediate care facilities	655,000
Physician services	17,525,000
Dental services	3,642,000
Prescription drugs	15,790,000

Source: Total number of recipients of Medicaid services was estimated on the basis of NCSS data for FY 1972, projected with the aid of data on the average monthly number of recipients and the trend in annual counts of recipients.

The distribution of these recipients by service assumed the continuation of the corresponding 1973 distribution, as contained in unpublished data from the National Center for Social Statistics.

Most of the expenditures under Medicaid (almost two-thirds) are for some form of institutional care, with about 30 percent for inpatient hospital services, 20 percent for skilled nursing facilities, fifteen percent for intermediate care facilities, 10 percent for physicians' services, seven percent for prescription drugs, six percent for outpatient hospital and clinic services, three percent for dental services, and nine percent for labs and x-rays, home health and other medical services. (Table 5)

Expenditures have been increasing by almost two billion dollars (Federal, State and Local) each year since FY 1974, with the major factor contributing to that increase, the inflation in the prices paid to hospitals, nursing homes, physicians, dentists and other practitioners. (Table 6)

Table 3

Distribution of Medicaid Recipients and Medicaid Expenditures, by Category of Eligibility, FY 1972

	Recipients (percent)	Expenditures (percent)
Total	100	100
"Adult" Categories	26	61
Aged	17	35
Blind or Disabled	9	26
AFDC and Other Categories	74	39
Under 21 years of age	46	21
21 years and older, under 65	28	18

Source: NCSS B-4 (FY 1972)

Table 4

Distribution of Medicaid Recipients and Medicaid Expenditures, by Maintenance Assistance Status, FY 1972

	Recipients (percent)	Expenditures (percent)
Total	100	100
Received Money Payments	73	55
Did Not Receive Money Payments	27	45

Source: NCSS B-4 (FY 1972)

Table 5

Distribution of Medical Vendor Payments
by Service, FY 1975 and FY 1976

	FY 1975	FY 1976
	(percent)	
Total	100.0	100.0
Institutional Care	66.4	65.2
Hospitals, Inpatient Services	31.6	30.0
General and TB	27.4	25.9
Mental Hospitals	4.2	4.1
Nursing Homes Services	34.8	35.2
Skilled Nursing Facilities	19.5	20.3
Intermediate Care Facilities	15.3	14.9
Ambulatory Services	33.6	34.8
Physicians' Services	10.4	10.3
Prescription Drugs	6.7	6.6
Outpatient Hospital Services	5.8	6.5
Dental Services	2.8	2.8
Other	7.9	8.6

Source: SRS/OA/FM/(OA25)May 1975

Table 6

Medicaid Expenditures, by Source of Payments, FY 1974, 75, and 76

	FY 74	FY 75	FY 76
	(billions of dollars)		
Total	10.6	12.4	14.2
Federal	5.8	6.8	7.8
State and Local	4.8	5.6	6.4

Source: MSA/DPPE/Budget Office

Table 6A

Medicaid Expenditures, by Source of Payments, FY 1974, 75, and 76

	FY 74	FY 75	FY 76
	(1974 = 100)		
Total	100	117	134
Federal	100	117	134
State and Local	100	117	133

Deficiencies of the program

The program has been harshly and justifiably criticized. In large part, Medicaid's deficiencies have resulted from its structure and from its trying to fulfill the objectives for which it was originally established. First of all, Medicaid has been primarily a State program, intended to be responsive to State needs, pressures, and capabilities. Within fairly broad Federal quidelines, States determine who gets medical care benefits, what benefits they receive, what providers may participate in the program, how much these health care providers may be reimbursed, and how the various 53 programs are administered and managed. The result has been great variation from State to State in the groups who have received assistance and in the amounts of assistance they have received. The quality of the care provided has been uncertain and information about the programs has been sorely lacking, at least at the Federal level.

The responsiveness of the Medicaid programs to Federal needs, standards and goals has been very limited, with the Federal agencies unable or unwilling to penalize the States for failures to perform at acceptable levels and unable, through Federal fiscal or statutory constraints, to provide adequate incentives to the States to adopt voluntarily the Federal performance standards.

Secondly, Medicaid has been directed toward assisting only certain members of the low income population who were considered by statute to be especially in need of help. The results have been that significant segments of the poverty population have been without Medicaid support --- childless couples and singles between 21 and 65 years of age, the working poor, the intact families and even certain categorically-related needy (aged, blind, disabled, or members of families with dependent children and only one parent capable of support) where the State budgets precluded their receiving public assistance. Nationwide, less than three-fourths of the poor currently receive Medicaid assistance, and in at least 17 States (Alabama, Alaska, Arkansas, Florida, Idaho, Indiana, Louisiana, Mississippi, Montana, New Mexico, North Dakota, South Carolina, South Dakota, Tennessee, Texas, Virginia, and Wyoming), the proportion in 1970 (the last year for which State data are available) was less than one-third. (Table 7) Furthermore, the goal of limiting eligibility to certain priority groups has, along with other factors, produced an administrative monstrosity in determining Medicaid eligibility.

Thirdly, the program has been primarily a financing program, directed toward relieving States of some of the burdens of providing medical care to the poor. Accordingly, too little has been accomplished through Medicaid toward overcoming the inadequacies of the health delivery system --- by improving the availability and accessibility of health services, the quality of the care provided, or the control of the use of unnecessary or excessively expensive services. In fact, the gigantic and "uncontrollable" nature of the Medicaid budget has served to prevent public agencies from adequately funding competing health resource programs which might have overcome these impediments. Furthermore, the availability of financing for certain

Table 7

Medicaid Recipients compared to Poverty Population 1970

	Medicaid Recipients (Unduplicated Annual Count) as a percent of:	
	Total State Population	Total State Low Income Population
Alabama	4	17
Alaska	-	-
Arizona	-	-
Arkansas	3	10
California	19	174
Colorado	7	61
Connecticut	5	75
Delaware	6	61
Dist. of Col.	15	91
Florida	8	27
Georgia	7	35
Guam	NA	NA
Hawaii	8	95
Idaho	4	27
Illinois	6	55
Indiana	2	24
Iowa	4	36
Kansas	6	45
Kentucky	10	43
Louisiana	6	23
Maine	6	44
Maryland	8	76
Massachusetts	NA	NA
Michigan	5	54
Minnesota	6	57
Mississippi	6	16
Missouri	6	38
Montana	4	28
Nebraska	4	33
Nevada	4	44
New Hampshire	4	45
New Jersey	5	55
New Mexico	6	28
New York	17	156
North Carolina	NA	NA
North Dakota	4	24
Ohio	4	36
Oklahoma	8	46
Oregon	4	38
Pennsylvania	10	93
Puerto Rico	NA	NA
Rhode Island	10	96
South Carolina	4	15
South Dakota	3	17
Tennessee	4	19
Texas	3	18
Utah	5	46
Vermont	8	71
Virgin Islands	NA	NA
Virginia	3	21
Washington	8	84
West Virginia	8	35
Wisconsin	6	59
Wyoming	2	19
United States (adj for NA)	8	59

NA-information not available for at least one of the factors--population, low income population, or Medicaid recipients.
- no Medicaid recipients

Source: Population, by States, USBureau of the Census, US Census of Population, 1970, voll partA;

Low Income Population by States, US Bureau of the Census, Current Population Reports, P-60, No. 86;

Medicaid Recipients, National Center for Social Statistics, B-4 (CY 1970)

SRS/MSA/OC/LR
7/13/75

high cost institutional services and for services for the chronically ill has provided incentives for their use to the exclusion of the development of preventive care and other more economical alternatives to institutionalization.

Medicaid's Future

It is probably inevitable that, within the next five years, the Medicaid statute will be terminated to be replaced by a program with higher national standards for eligibility, benefits covered, and with greater ability to control costs while positively affecting the delivery of health services. It is also inevitable that the program which replaces Medicaid, whether national health insurance or another intermediate step toward NHI, will be more expensive than Medicaid. To offset some of these additional costs, it is likely that those who prepare the substitute will try to maintain the principle of State financial contributions to health care for the poor. Whether that fiscal contribution will also include further State involvement and even State management will depend, in large part, on whether the States have the capability to administer such a program and whether they have demonstrated, through their Medicaid experience, their willingness and ability to influence positively the administration of the program.

The next few years will be crucial in at least three respects. First and most significantly, the next five years represent an obligation to administer effectively and accountably a program which will cost a total additional amount of over seventy billion dollars, which will provide medical assistance for over thirty million people, and which will continue to affect, for better or worse, the health delivery system of every American. Secondly, they provide the proving ground to develop the needed Federal and State capabilities to manage a health financing program (e.g., utilization control, rate setting, cost control, fraud monitoring). Thirdly, they provide us with an opportunity to learn from the 53 programs, the lessons which will assist in the preparation, persuasiveness and development of a more effective and more economical health insurance program. For example, to what extent have the experiences of Medicaid demonstrated the appropriateness of the Federal/State partnership, the problems of a means-tested health program, or the advantages of capitation arrangements?

The Social Security Amendments of 1972 provided extensive changes in Medicaid which were intended to develop more effective systems of controlling costs and assuring that only necessary and economical services were reimbursed. It has been suggested that there should be no further legislative band-aids before the major Medicaid-ectomy; and that the emphasis over the next few years should be in implementing the current statute and in managing Medicaid within its present general mandate.

This document strongly recommends that a different position be considered; legislative changes are needed. Within the same frame-

work of an effective Federal/State partnership, the Medicaid statute should be amended to simplify the requirements, particularly in the area of eligibility, to reduce some of the inequities, and especially to make it possible to administer the program in a more effective and economical manner.

If the current economic and political conditions continue, the Administration may prefer to avoid a massive overhaul of all the health financing programs through national health insurance. In that case, amending Medicaid may make it possible to remove some of the pressure for NHI, while overcoming some of the most urgent deficiencies of the current health insurance situation and filling the most pressing gaps in health financing.

The Major Medicaid Solution

There are a number of significant policy questions concerning Medicaid which require resolution over the next 18 months. The attached chapters examine these issues in detail, provide background on each of the questions, explore possible solutions and recommend a Departmental position with regard to each problem. The next section will serve as a guide to the issue papers, summarizing salient points and recommendations; and directing the reader to the location of more complete examinations of these essential issues.

One common theme permeates these issues. The organization and staff resources of MSA and its Regional Office counterparts need to continue to be strengthened. Many of the surmountable failures of Medicaid to fulfill Departmental and Congressional expectations and to implement the law have stemmed from the Federal organizational arrangements developed to administer the program and in the lack of adequate staff and appropriate skills. This organizational structure derived. in large part, from its origin as essentially an in-kind welfare program, with little expected Federal presence and similarly little intended influence on the health delivery system. Recently, the Medicaid links to the welfare programs have become more tenuous, with the enactment of the Social Security Amendments of 1972, which made Medicaid eligibility no longer an automatic consequence of welfare eligibility, which separated the bureaus administering the various cash assistance programs, and which increased the Federal administrative involvement in the SSI programs.

More recently, there has been increasing pressure for a more clearly evident and single voiced Federal presence. This has been demonstrated repeatedly by Congress in the frequent hearings and reports on Medicaid, particularly on fraud, on nursing homes and on EPSDT; in the the introduction of at least five new major Federal penalties for failures to implement portions of the Medicaid statute; in the allocation of specific additional slots to MSA for such programs as EPSDT; and in the Congressional insistence on the submission of regular reports on our implementation of these measures and on Medicaid spending.

Furthermore, any implementation of major health financing programs requires close liason with the health agencies. This link should continue to be reflected in the organization of the Central Office, the Regional Offices, (where program monitoring, information gathering and technical assistance must take place) and in the liaison arrangements between them.

The size, level and skills of the Medicaid staff have not reflected the increasing expenditure, functions and complexities of the Medicaid program. In fact, the current size of the Central Office despite generous decisions on the part of the Secretary and the Congress, is only 190, of which 135 are filled. This is very little more than the size of the bureau in 1970, when expenditures were less than half of the current level and the Medicaid Task Force declared the staff woefully insufficient to meet the considerably less complex burdens of administering the early stages of the program.

Of critical importance to the successful management of the Federal role in Medicaid would be the recruitment of highly specialized skills and experience in a number of technical areas which are currently under-represented in both the Central and Regional Offices. These include experts in the operation of State Medicaid programs, medical and dental sciences, health care organization, health financing, insurance and actuarial sciences.

The Talmadge Bill, which the Senator has announced he will introduce within the next few months, represents the ultimate dissatisfaction with the Federal/State partnership on which Medicaid is based and the current methods of organizing Medicaid's Federal role. The Bill would establish a Health Financing Agency, consisting of the Medicare, Medicaid, Nursing Home, and Quality Assurance Units

of the Department and would change the relationship of this agency with the Medicaid agencies and providers. The Bill demonstrates the Finance Committee's discomfort with the present administration of Medicaid ("MSA is weak and lacks credibility"), but it also shows the Committee's determination to enter into the organization of the Executive Branch, and its own conclusion about the inevitable Federal nature of the administration of NHI. The best response to the Bill would be clear evidence of the efficacy of the Federal/State partnership and the strength of the Federal management of its Medicaid role.

Summary of Medicaid Issues

We emphasized earlier that our strategy is directed toward improving the Medicaid program; fulfilling our obligations to assist the States to provide medical assistance to the needy, in an effective and economical manner; and helping to have Medicaid serve as the proving ground for a better system of health care financing. Consistent with these goals, we have addressed the following significant issues:

I. Management Improvement

(1) What are the options in improving State management of Medicaid and what should be the Department's strategy? To understand the Department's options, it is important to recognize the inherent advantages and disadvantages of the Federal/State program relationships. The advantages of having the States participate financially (almost seven billion dollars a year), carry the additional benefits both of responsiveness to local conditions as well as of State concerns for the control of costs and for the efficiency of the system. Some of the most effective and innovative measures in controlling health costs have been introduced through State Medicaid programs.

On the other hand, this cost control (particularly in this period of economic recession, limited State fiscal resources and competing demands for social welfare expenditures) has meant that States have concentrated their efforts on reducing their financial commitment to Medicaid, trading off many of the other objectives of the program. Enforcement of standards of medical care has not always been maintained; reimbursement methods have not been optimal. To assure that this cost control is effective and compatible with the Federal goals of assuring the availability of needed services to eligibles, in conformance with Federal regulations and standards, the Federal government may employ only a limited set of options with regard to the Medicaid program. Nowhere is it more obvious than in Medicaid, that "governments (in this case, the Federal government) derive their just powers from the consent of the governed (in this case, the States)".* The options for improving the Medicaid program

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* Thomas Jefferson, Declaration of Independence, July 4, 1776

and achieving Federal objectives, therefore run the gamut from:

....providing information to the States about exemplary practices and research on costs and benefits of different processes; to
....subtle persuasion and pressures from the press, political action groups and the public; to
....technical assistance on how best to accomplish the implementation of Federal requirements; to
....comprehensive reviews and public hearings on assessments by Federal staff of an entire State Medicaid program; to
....selective withdrawal of FFP for improper State payments to certain priority program areas; to
....compliance hearings; and finally, reluctantly, and rarely, to
....penalties arising out of the findings of these hearings.

The processes of persuasion and advice are frequently unavailing and are inevitably very slow. At the other extreme, withholding of Federal funds to "beat" States into performing according to Federal standards, tends to be counterproductive in that it strikes the most innocent, the Medicaid recipient. For that and other political reasons, it is rarely invoked.

Improving the management of State Medicaid programs will be a delicate balance of guiding, luring, pulling and occasionally shoving. A set of recommended techniques is included in the attached issue papers.*

If it were possible to reduce the complexity of the Medicaid statute and consequently to simplify the Federal regulations and other Federal requirements, the problems of improving State management of Medicaid and of implementing Federal policies would be eased substantially. The payoff warrants further consideration, particularly in the area of Medicaid eligibility.

It has been particularly difficult to develop improvements in State management and to monitor for compliance with Federal regulations in the absence of adequate, timely, reliable and accurate Medicaid data at the State and consequently at the Federal level. The lack of management information systems (and claims processing systems) has been conducive to the notorious abuses of the Medicaid

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* For a more complete discussion of the options and recommended strategies to improve the management of the Medicaid program, see attached:

A. Management Improvements
   Regulations, Compliance and Sanctions
   Performance Monitoring
C. Eligibility
   Improvements in Management

program. The lack of operating informations systems has hampered the preparation of informed policy concerning utilization and utilization control, fraud, abuse, reimbursement of providers, eligibility standards and quality control of Medicaid eligibility.

State progress toward developing automated information systems has been steady, but painfully slow (despite incentive Federal matching). Extraordinary efforts (of both "carrot" and "stick") will be required over the next few years to obtain the needed accelerated rate of development of State Medicaid Management Information Systems. Furthermore, methods will be used to assure that the MMIS systems will result in improved availability of information at the Federal level. The beneficial effects of improved information systems would then be reflected throughout the 53 programs, and in the national understanding of Medicaid.

(2) What program initiatives are needed to reduce the incidence of fraud and abuse under Medicaid? Considerable attention has been focused on the existence of provider fraud and abuse in Medicaid. While it is obvious that improper vendors constitute a very small proportion of the providers who participate and are reimbursed under Medicaid, the existence of any fraudulent activities diverts scarce funds from necessary medical services, besmirches the reputations of other providers (and discourages their participation) jeopardizes the financial integrity of the Medicaid system and raises doubts about the ability of the Federal and State governments to manage the system. Accordingly, with extensive Administration and Congressional support, the Department is proceeding to expand its fraud and abuse control activities. Consistent with our interpretation of the appropriate Federal/State relationships in Medicaid, the strategy which we propose will rely on State systems to perform the functions of identification, referral, and tracking of suspected cases of fraud. The Federal role will be to assure compliance with Federal regulations on State fraud control systems and to make available to the States the kind of assistance needed to improve their State systems.*

II. Cost Control

The rapid increases in the costs of the Medicaid programs have created concern, not only by the Federal and State governments which pay for them, but by all other competing purchasers of medical care services. Demands have been generated for measures which would control the rates of inflation in medical care costs, provide incentives for efficiency and economy, and reduce the utilization of inappropriate and expensive health services. As noted earlier, some States have devised and maintained innovative and effective measures for controlling certain medical costs. It would be a delusion, however,

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* For a more complete discussion of the initiatives to be undertaken in the area of fraud and abuse, see:
A. Management Improvements
Fraud and Abuse

to believe that these commendable practices are spread widely throughout the services of any one State or spread widely from State to State.

A good portion of the Federal efforts in controlling the costs of Medicaid will be devoted to alerting the States to the potential benefits of particularly good State practices, advising them of how to introduce such measures and how to avoid the pitfalls which are inherent in some of them. Consideration will be given to requiring States to adopt certain cost controlling techniques, whose advantages would clearly justify such action.

Utilization Control*

The Federal Government, the States, and the Medicaid recipients have an interest in assuring that only necessary medical services are provided under Medicaid, and that surgery, hospitalization, and other institutional care are kept to a minimum. Despite these vested interests in avoiding institutional services, one of the explanations presented for the increases in Medicaid costs has been the unnecessary and over-utilization of costly institutional care.

The 1972 Amendments to the Social Security Act were intended to strengthen the cost containment features of Medicaid, and they expected to accomplish this goal through such utilization control measures as PSROs, Cost Sharing, and penalties for inadequate State systems for utilization review. The opposition of certain provider groups and entanglements in court have delayed the introduction and implementation of many reforms of the utilization review process. As soon as the authority to introduce these reforms is clarified, and the appropriate organizational arrangements may be made, then it will be reasonable to expect an improvement in the allocation of health care resources and an increase in the quality of care, or at least in the placement in more appropriate kinds of care.

Any cost reductions would be additional bonuses, but it should be emphasized that it is not at all certain that they will be forthcoming. Transfers to "lower" levels of care do not always mean transfers to less expensive care. For example, care in an intermediate care facility usually involves less nursing expense than does the care of a skilled nursing facility. On the other hand, the services and the capital equipment needed for ambulatory and rehabilitative services frequently outweigh the costs of nursing services. Increased costs are also likely to result from transfers from institutional to non-institutional settings. Significantly, utilization review may reveal inadequate care, thus potentially generating additional costs.

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* Some of the major issues in utilization control under Medicaid are presented in attached issue papers.

One of the major functions of utilization control will be to reduce the incidence of abusive and even fraudulent practices. Of considerable assistance in these efforts will be the development in many States of patient and provider profiles, preferably of a sophisticated automated nature. Such records would reveal more easily instances in which inappropriate utilization of services have taken place. For example, profile systems would identify providers who had received extraordinary income from Medicaid or performed abnormally large numbers of services; or eligibles who had consumed inordinate amounts of prescription drugs.

Progressing simultaneously with the improvement in the more traditional methods of utilization review, will be the advances through the introduction of the Professional Standards Review Organizations (PSROs). These peer review groups, developed through local medical groups, are intended to replace other Medicaid review mechanisms. Until that time, all other utilization review procedures and automated surveillance and utilization methods are expected to be compatible with the development of PSROs.

Problems, peculiar to the Medicaid Federal/State relationships have arisen with regard to Medicaid and PSROs. Title XIX has held the States accountable for performing adequate utilization review. While the Secretary has declared that the States are relieved of this responsibility where there is approved conditional PSRO, the States may not be eager to relinquish this accountability and responsibility.

1. The utilization review mechanism determines the medical necessity for medical care and whether the individual has received services appropriate to his needs. As has been demonstrated earlier, the transfer of patients to more appropriate kinds of care may not mean decreases in costs, and may even mean increases. States are reluctant to entrust the responsibility for determining the expenditure of public funds to private societies, particularly organizations of providers of health care.

2. PSROs are currently limiting their scrutiny to institutional services, or about ten billion dollars of Medicaid services. States will still be expected to maintain utilization review activities for those areas not covered by PSROs. These might include the non-institutional services, as well as the geographic areas in which there were no PSROs established. In addition, States would probably continue to want to monitor the activities of PSROs to assure that the UR functions were being adequately performed. The results would be costly duplication of efforts, and confusion on the part of providers about the UR methods.

Many of the States have expressed their discontent with the PSRO conditions. Some have proposed amendments to the legislation to waive the PSRO sovereignty over State Medicaid agency UR activities. Others have attempted to impede the PSRO development in their States. Still others have attempted to negotiate more favorable terms, through the "memorandum of understanding" which the State agency

signs with the PSRO. Medical services will have to work closely with the States over the forthcoming year to reduce some of the difficulties and to facilitate the development of PSROs in Medicaid.

Increasing Third Party Payments

The Medicaid statute requires the States to exert all reasonable efforts to recover third party resources in payment of title XIX costs of services incurred by recipients. Insurance companies which had received premiums for medical coverage would be expected to provide those benefits despite the fact that the insured might be a Medicaid recipient; States would be obligated to recover this reimbursement.

Despite the interest that the States have in increasing these third party payments, they have not rigourously pursued a program of recapturing these resources. Estimates of the savings in public funds which might accrue from a more earnest effort have varied from $12.5 million, as estimated by GAO, to $100 million, if all States were able to glean an amount corresponding to that recovered by the State of Washington.

As part of the programs to reduce public costs, attempts will be made to identify practices of recapturing third party payments, which would be useful to the States. The States will be aided and abetted in these efforts by Federal Regional Financial Management teams and guides.

Reasonable Cost Related Reimbursement to Nursing Homes

The Social Security Amendments of 1972 established that all State plans were required to provide for payment of services in ICFs and SNFs on a reasonable cost related basis. The measure was introduced in view of concern expressed that under the current reimbursement methods, some ICFs and SNFs had been overpaid by Medicaid, while others were paid too little to support the quality of care needed by Medicaid patients.

The Secretary's regulation is supposed to be effective July 1, 1976, and SRS has been proceeding with due speed to complete the actions necessary for the issuance of the regulation.

Two major events have served to impede the issuance of the regulation:

1) A number of definitions and similar issues, involved in the regulation, are extremely controversial, and do not lend themselves to ready resolution before the July 1, 1976 deadline. These include all allowances for depreciation, including the value of sold

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* Third Party Payments are discussed in an attached issue paper on the subject.

or transferred assets, and allowances for a reasonable return on equity (profit).

2) There have been various charges that the reasonable cost related reimbursement method would permit homes to pass in increases in costs, and that this fact, coupled with the increased enforcement of improved nursing home standards, would result in huge increases in the costs of Medicaid nursing homes. This allegation has been questioned by many, who believe that the results of a reasonable cost related reimbursement method would be to permit adequate quality of care to be purchased, while reducing the enormous profits which characterize much of the nursing home industry.

In the absence of consistent and reliable cost accounts, it is highly unlikely that these controversies will be settled. Accordingly, it is recommended that the Department engage in the steps necessary to mandate uniform charts of accounts and cost reports for the Medicaid nursing homes. These reports should provide the basis for determining the extent of the cost increases which would result from the introduction of reasonable cost related methods. It is therefore urged that the Department press for a delay in the implementation of the reimbursement requirement, until obtaining the results of the analysis.*

Prospective Reimbursement to Hospitals

A major area in which the Medicaid programs have been credited with introducing creative and potent cost control has been in prospective reimbursement rates to hospitals. Since inpatient hospital services constitute almost one-third of the more than fourteen billion dollar Medicaid program, the potential gain from extending the use of effective measures would be enormous. Prospective reimbursement appears to be successful particularly in comparison to the more traditional reimbursement approaches which involve paying for almost all costs and cost increases, without critical incentives for efficiency and economy.

As advantageous as these prospective methods may appear to be, however, it would be premature to require their introduction in every State. At this stage, it is probably still preferable to convince, cajole and convert the States to explore the various budget and formula approaches to improving their reimbursement mechanisms. While encouraging methods which would work toward consolidating facilities and producing more optimal occupancy rates, we must constantly guard against driving needed hospitals into insolvency, or reducing the availability of hospital services for Medicaid recipients.**

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* A fuller discussion of the options and recommendation appears on the attached issue paper on "Reasonable Cost Related Reimbursements" in the Cost Control section.

** An issue paper on "Prospective Reimbursement to Hospitals" appears in the appendix to this report, as a background document.

Legislative Proposals

Two amendments have been proposed by the Administration to reduce Federal costs of the Medicaid program. One would lower the minimum Federal Financial Participation (FFP) from the current fifty percent minimum to forty percent. The resultant Federal savings would amount to $600 million to one billion dollars, depending upon whether the States maintain only their current planned level of expenditures or instead increased their spending to absorb the cutback in Federal spending.

The second proposal would eliminate FFP for dental services for adult eligibles for Medicaid. The Federal savings, in this case, would amount to about $85 million. This amount might be offset by the proposed increased FFP for EPSDT dental services. (See EPSDT issue paper).

Both of these proposals have encountered resistance from the States and neither appears likely to be enacted shortly.

III. Eligibility*

Medicaid eligibility is one area of the program which has fallen victim to all of the vagaries of the conflicting objectives for which the program was created. To permit complete flexibility and responsiveness to State needs, capabilities and pressures, Medicaid eligibility conditions have been permitted to vary dramatically from State to State. Efficiency of Federal monitoring and equity in treatment of possible eligibles have consequently been sacrificed.

To assure that only certain high priority categories received assistance (i.e., the aged, the blind, the disabled, and the families with only one able parent), horizontal notches have been created. Two individuals with exactly the same income or medical need may receive two different Medicaid eligibility determinations. (For example, a widow of 64 with no income must wait a year, until she is 65, before she can expect help in paying for medical care.) Furthermore, the welfare categorical definitions, which determine Medicaid eligibility, establish an additional undesirable incentive for families to break up, in order to get help.

Tying Medicaid eligibility to welfare eligibility frequently means that the need for medical assistance becomes a less significant factor in determining whether an individual is eligible for Medicaid, than the source of his income. Furthermore, when major needed changes in the welfare programs are undertaken, their impact on Medicaid is frequently not anticipated and often disastrous. The federalization of the adult cash assistance programs required all sorts of

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* Medicaid eligibility problems and the solutions for improving Medicaid management and for overcoming inequities are analyzed in the attached set of issue papers.

complex defensive reactions by Congress and the States, to protect the States from expected mammoth increases in Medicaid eligibility rolls and consequent fiscal burdens. The distortions and complexities which have resulted have created an administrative monstrosity out of Medicaid eligibility.

The regulations which govern Medicaid eligibility were recently completely overhauled to simplify them and to make them consistent with the many changes which have taken place in the statute. Some marginal simplification might still be possible. On the other hand, most of the States have not caught up with earlier changes. Further amendments might create more confusion than conformance.

As an attempt to control costs and to improve the credibility and integrity of the Medicaid program, SRS has undertaken a system of quality control of Medicaid eligibility. This system parallels in many respects the systems introduced into the AFDC program to assist the States to improve their eligibility determination processes. Handbooks and guides are prepared and tolerance levels are set for acceptable State performances.

The Medicaid eligibility determination is considerably more complex than that of AFDC cash assistance. In addition to the categorical income and resource requirements, consideration must be given to such factors as the volume and timing of incurred medical expenses, the relationship to other health insurance programs, the kinds of medical care benefits appropriate to the particular category, and the timing of the benefits.

The goals of Medicaid QC are similar to those of AFDC-QC; that is, that only those eligible for service receive services and that the State system assure the validity of this. On the other hand, expectations of State achievements are considerably less for Medicaid eligibility and the probability of Federal establishment of numerical targets with penalties for noncompliance is still remote.

At the same time that the Department is attempting to improve the management of the State Medicaid eligibility activities through QC, it should attempt to reduce the complexity and the administrative infeasibility of the function.

It is proposed that the Administration consider the introduction of legislative proposals which would simplify the conditions under which States determine Medicaid eligibility. Various legislative solutions are possible depending upon the priorities we wish to place and the resources we want to devote to medical assistance for the poor.

The improved program would then make it possible to conduct a more reasonable test of whether a Federal/State program which is income tested can be effectively operated.

IV. EPSDT - Child Health*

The Social Security Amendments of 1967 established that States were required to provide, for all Medicaid eligible individuals under 21, screening for physical or mental defects, as well as diagnosis and treatment to correct such defects. The regulation defined the required EPSDT services in general terms, but emphasized that all States must provide children with all of the needed medical services provided Medicaid adults, plus treatment for visual, hearing and certain dental defects. All Medicaid State EPSDT programs were to be fully operational by July 1973.

A penalty provision, effective July 1, 1974, was an expression of Congressional dissatisfaction with the slow progress in implementing the program. In executing this provision, the Secretary has withheld one percent of the title IVA (AFDC) funds for seven States (Hawaii, Indiana, Minnesota, Montana, New Mexico, North Dakota, Pennsylvania) for the first quarter of FY 1975 for failure to perform satisfactorily in their EPSDT programs. Other States may also be penalized for the same period.

Of the 2.2 million children (out of the 13 million eligibles) who have been screened through the program, about half were referred for treatment, the largest proportion of them for correction of dental defects.

The EPSDT program provides the States with Federal financial and technical assistance so that needy children may receive necessary health care. Instead of the traditional crisis-oriented, high cost care, EPSDT provides an opportunity for case management and a coherent approach to solving child health problems. States can obtain management experience in organizing and delivering health services, while keeping costs under control. The usefulness of this experience for immediate health objectives, as well as for the success of future NHI programs is obvious.

The Federal strategy will involve four closely related efforts:

1. Facilitating the integration of all of the now scattered functions of outreach, screening, referral, diagnosis, treatment, tracking, and periodic re-screening into full case management. This will include technical assistance to States and to providers, the development of a management information system for EPSDT, analyses of the impact of the program on children, and identification of exemplary practices by States, provider groups and volunteer organizations.

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* The attached issue paper on EPSDT describes in more complete detail the history and proposed strategies for the program.

2. Changes in the methods of fiscal sanctions to assure State compliance. One proposal might be to assess the penalty against the administrative funds, rather than welfare funds.

Two legislative proposals to overcome the reluctance of States to commit themselves to EPSDT:

3. Federal financial incentives to provide dental services, the most expensive deficiency for needy children as a group.

4. Extension of eligibility to allow continuity of treatment undertaken through EPSDT program.

V. Long Term Care

Forty percent of Medicaid's fifteen billion dollar expenditures this year will be devoted to long term care of the aged and the chronically ill. These services include care in skilled nursing facilities, intermediate care facilities, and some portion of the services in general and mental hospitals. In addition to the institutional care, less than one percent of Medicaid expenditures are devoted to home health services and other alternatives to institutionalization.

Organization of the Department's Long Term Care Programs*

In the Central Office, Long Term Care staff are located in the Office of Nursing Home Affairs in ASH, a Special Assistant for Long Term Care in the Office of the Secretary, in the Bureau of Quality Assurance in HSA, and in the program bureaus with operating responsibility for the Federal role in Medicare, SSA/BHI, and Medicaid, SRS/MSA. The Regional Office staffs are concentrated in each of the Regional Offices of Long Term Care Standards Enforcement (OLTCSE), located in the Offices of the various Regional Directors.

This organizational structure represents in part a response to the concern that the nursing homes were not fulfilling standards for care and safety and that greater visibility of the Federal presence would help to overcome these deficiencies, and secondly, that there was a need to unify and coordinate the Federal policies and activities with regard to Medicare and Medicaid institutions.

It is clearly too early to evaluate whether the current organizational structure has resulted in an adequate improvement in the fulfillment of nursing home standards. Certainly, there has been no decrease in the Congressional investigations and criticism of Deparmental activities. It is not, however, too early to examine whether the organizational structure is theoretically compatible with Federal objectives. At least two major Department studies have been undertaken to examine this question and at least two bills have been introduced in this session, based on different assumptions about the ideal organizational structure.

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* The Organization of Long Term Care Programs is discussed in detail in the attached issue paper on that subject.

In evaluating the long term care organization, it is important to note that ONHA was established to coordinate the policies which were common to Medicare and Medicaid in nursing homes, but that in this area, these two programs are probably more different than they are similar. Their differences apply to the benefits covered, the patients and illnesses addressed, the facilities used, and most significantly, the statutory basis for regulation, enforcement and reimbursement of the nursing homes.

Medicare limits its nursing home benefits to acute post-hospital care in skilled nursing facilities; Medicaid covers skilled nursing homes as well as intermediate care facilities, about 12,000 institutions. Medicaid benefits are more frequently long term care benefits.

Medicaid patients in nursing homes tend to have exhausted all other possibilities of medical care and living arrangements; they tend to be the poorest and the sickest patients. Their medical, rehabilitative and social needs tend to be different from those of Medicare patients.

The greatest differences are found in the fact that Medicare is a Federal program, in which the contractual arrangements are between the Federal government and the providers; Medicaid is a Federal/State program and the contractual arrangement which is being enforced and monitored is between the Federal government and the State governments. The advantages and the disadvantages of the Federal/State partnership have been emphasized throughout this document. Unfortunately, the essential character of this relationship is frequently overlooked when attempts are made to consolidate Medicare and Medicaid long term care programs into the Medicare Federal mold.

The Department appears to have three options in developing a long term care organizational model. It can retain the current structure, it can develop a long term care agency, or it can maintain the ONHA and the OLTCSE for policy coordination and assistance to the program bureaus, while distributing the bulk of the staff and functions back to the program bureaus. The attached issue paper argues that the third option is essential for the successful implementation of the Federal role in Medicaid long term care programs and for the demonstration of the appropriateness of a Federal/State partnership in medical assistance for the needy.

Personal Needs Allowances*

All of the one million individuals who reside in Medicaid institutions are assured of a certain amount of money each month for their own personal needs. These funds, possibly $300,000,000 per year, are provided either through the cash assistance programs, or are retained out of personal income, after the individual has paid for some of his own medical care.

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* See issue paper on Personal Needs Allowance for a fuller examination of this question.

Instances of abuses of these personal needs allowances have been identified by HEW Audits, GAO surveys, SSA and SRS Regional Office surveys, Congressional queries, newspaper articles and letters from the public. The extent of these abuses is unknown, but the potential for abuse is great. Personal Needs Allowances, intended for the use of the patient have not been made available to her, the personal services for which they were intended have not been accessible, the patient has been charged out of her personal needs allowance for services also reimbursed through the Medicaid program, and the funds have accumulated and been diverted to other uses, organizational entities or individuals.

While the problems have been recognized, there remain great questions about the remedies. Are there statutory bases for Federal intervention? Are the State Medicaid agencies responsible; or should they be held responsible? The funds are derived from multiple sources and not through the Medicaid program. Is any public intervention appropriate, or does the individual patient have a right and an obligation to manage her own personal financial affairs?

A Task Force consisting of the various interested Federal agencies -- SRS (MSA and APA); SSA (OASDI, SSI, and BHI); H (ONHA and BQA); P; C; and L should be convened to explore the question of the control of Personal Needs Allowances.

Domiciliary versus Medical Care*

Prior to PL 92-603, States could purchase medical care for welfare recipients, either through Medicaid vendor payments to providers, or by including the medical service costs in calculating the cash welfare payment to the recipient. Institutions might avoid having to conform with Medicaid standards of fire safety, sanitation and quality of care, by withdrawing from the program and continuing to receive support through additional welfare payments. The problem became more intense as the department stepped up its efforts to enforce nursing home standards. FFP was therefore available to institutions which did not meet Medicaid standards; the incentive to correct deficiencies was thereby eroded.

To correct this failing, PL 92-603 established that there would be no Federal matching of any portion of a State's cash payment which was used to pay for institutional medical or remedial care which was, or could have been provided under an approved State Medicaid plan in an institution certified for title XIX participation. PL 93-233 extended this intent to apply to the new federalized SSI program, by stating that SSI payments would be reduced by the amount of the State supplementary payments which was used to pay for such remedial or medical care.

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*An attached issue paper, Medical versus Domiciliary Care, examines this question in somewhat greater detail.

A definition of "institutional inpatient medical or remedial care which is or could be provided by an institution certified under title XIX" is essential to implement these statutes. This definition would have to distinguish between care which could be delivered in a title XIX facility if it were able to meet the requirements of title XIX and institutional care which was essentially a congregate residential facility.

Such distinctions are relatively obvious at the extremes, where the institution is a skilled nursing facility requiring considerable medical and nursing care, or where the institution is a residence for individuals who are ambulatory, in good health and receiving only recreational services. The cut is considerably harder to make and to justify when the institutional services are primarily "health" related, but not necessarily medically related.

The Medicaid statute and regulations have defined the standards that title XIX institutions must meet; it is recommended that the Medicaid agency develop a Program Regulation Guide which would spell out in complete detail the conditions determining title XIX type care. These conditions should lend themselves to ready administration and interpretation by the SSI and AFDC agencies responsible for withholding the Federal funds. At the same time, SRS should revise or clarify the regulation which has defined the conditions for withholding FFP for AFDC recipients in institutions.

It is important to assure that Federal reimbursement is not made available for substandard care. On the other hand, it is also important that reimbursement is not withheld for care which is appropriately reimbursed as income maintenance or social services.

Appendix

In addition to the significant program issues for which Secretarial decisions will be required, there are a number of Medicaid issues which warrant further exploration. After more profound study is made of these areas, some policy changes and legislative proposals may be forthcoming. These Medicaid areas include: cost sharing; alternatives to institutional care; mental health programs, mandating minimum reimbursement rates; capitation arrangements, both on a Statewide basis and in HMOs; female recipients of Medicaid; and health education. Issue papers on each of these topics are attached in the appendix to this document.

A further set of papers have been presented as background documents. They regard issues for which no resolution is apparent or needed at this time.

Medicaid Issues to be Discussed at the Secretary's Conference on Planning Health Financing Programs

July 31, 1975

ISSUE: How should Federal policies and operations be changed to improve the management of the Medicaid program? What resources are needed to achieve a significant improvement? Are legislative changes required?

BACKGROUND: The Medicaid program has been harshly criticized for the "uncontrollable" character of its expenditures and for the failures to provide convincing systematic evidence of effective program management and administrative responsibility. More significantly, the Federal government has been chasitised for insufficient accountability for program operations; for not providing adequate leadership and guidance to the States; for failure to enforce statutory requirements; and when specific penalties were enacted to reinforce these Federal requirements, for failures to implement these penalty provisions.

Favorable press coverage has been remarkable in its rarity. The attacks by Congress have been both general and specific. Senator Talmadge's explanation for introducing a bill which would reorganize the Federal health financing agencies was based in part on his statement that "MSA is weak and lacks credibility". Legislative proposals to federalize medical assistance to the poor have emphasized apparent weaknesses in Medicaid.

Congressional hearings have repeatedly been called on various aspects of the Medicaid program -- fraud, nursing homes, EPSDT, utilization control, prepaid health plans and program and discretionary budgets. Few of these hearings have ended on a note which indicated Congressional satisfaction that Federal efforts were sufficient.

Many of the problems of the Medicaid program are inherent in the fact that compliance hearings and general sanctions against a State are difficult to execute and could invoke hardship on the program recipients, the targets of program activities.

On the other hand, there is much which could be accomplished to improve the Medicaid program and to overcome much of this criticism. But there would have to be Federal resolve to do so, and this resolution would have to be accompanied by the commitment of adequate and extensive resources.

To achieve these goals would require an estimated total new staff for the Federal Medicaid program of 720 people, in addition to the current slots of 190 in the Central Office and 130 in the Regional Offices, and the 108 slots which have been requested in the FY 1976 budget. These are the numbers which we estimate are necessary to implement P.L. 92-603, to achieve the degree of accountability which is being expected of the Federal role in Medicaid, and to demonstrate the feasibility and desirability of a Federal/State program for providing medical assistance to the needy. These estimates are rough and are based on current GC interpretations of the amount and frequency of

Federal surveys which are legally required.

Briefly, the new staff would be required for the following major program activities (in addition to the current on-going operations):

1. Improving Performance Monitoring, which involves:

a. establishing performance criteria for critical operational components of a State system, and then monitoring all States against these criteria;

b. identifying the best program policies and operational practices developed by individual States, identifying which additional States should adopt these policies or practices, and providing technical assistance to States in their efforts to improve their programs.

Additional staff needed -- 50

2. Provider Fraud and Abuse, which addresses fraudulent and abusive practices among providers of Medicaid services through evaluation and monitoring of the States' fraud and abuse surveillance activities. Evidence from Medicare and similar activities indicate that this attempt to achieve program integrity will consume vast amounts of staff resources, to deter or to penalize program abusers.

Additional staff needed -- 115

3. Medicaid Eligibility Quality Control, which is directed toward the proper determination of recipient eligibility by the States, and Medicaid eligibility reform, directed toward simplifying Medicaid eligibility requirements.

Additional staff needed -- 70

4. Financial Reviews, addressing State financial management of the Medicaid program to assure appropriate FFP. Of importance would be the verification that third party resources had been appropriately used to offset Medicaid costs (with possible Medicaid savings on this item alone of $100 million).

Additional staff needed -- 100

5. Utilization Control, addresses the utilization of services to assure their medical necessity and appropriateness. Efforts in this area include the negotiatinns with States and developing PSROs, the development of State systems for provider and patient profiles, the enforcement of new regulations on UR, and the enforcement of the mandatory reductions in FFP for certain long term care stays for State failures to maintain adequate UR systems. The major factor in determining the size of the additional staff needed will be the frequency with which the Secretary must validate the findings of satisfactory UR systems, and the number of surveys which must be conducted in order to provide sufficient legal justification to withhold FFP. GC is preparing

an opinion on whether the States may be expected to assume a larger share of this burden; we will revise the estimate of staff requirements if the GC interpretation is changed. Based on current GC interpretation, then the minimum

Additional staff needed -- 200

6. Sterilization. Considerable staff will be needed to verify the fulfillment of the requirements that sterilizations under Medicaid were conducted only on voluntary recipients who gave their informed consent to the procedures. Court ordered requirements have been explicit and exacting.

Additional staff needed -- 25

7. Family Planning to assure that States provide the required services, and receive appropriate FFP for these services.

Additional staff needed -- 5

8. EPSDT. Increased Congressional investigations of this area, and more recent interpretations of the periodicity for Departmental surveys of State performance, in order to invoke the penalty, suggest that additional staff resources are needed. This will be particularly true in view of the thrust to assure that the program concentrates on case management and assuring that the most effective and economical child health measures are provided.

Additional staff needed -- 135

9. Reimbursement. P.L. 92-603 establishes a number of areas where the Secretary is required to verify the effectiveness of reimbursement methods as well as a number of opportunities for the Secretary to encourage the States to develop economical reimbursement techniques. These include reasonable cost related reimbursement to nursing homes, prospective reimbursement to hospitals, cost sharing and capitation arrangements.

Additional staff needed -- 20

The additional staff resources of 720 persons would be needed to complement the 428 positions which would be available as a result of the 1976 budget request. While the increase in staff would be a monumental undertaking, the resulting annual administrative costs would still be less than one half of one percent of the Federal Medicaid program costs.

The absence of the increased stafff would invoke further censure by Congress, the press and the public for failure to implement the program and control the costs. Further criticism will probably result in further explicit demands for Federal action, further specific penalties. Despite the logical inconsistency, weakness in the Federal role in Medicaid, will provide further vindication for the proponents of federalization of health insurance programs.

RECOMMENDATION: SRS recommends that a profound analysis be undertaken of the staff resources needed to fulfill the Federal commitments in the Medicaid program area; that additional staff resources be recommended to OMB, so that requests to Congress may be made at the earliest possible date. In default of the additional slots, the Department should advise the Congress of the difficulty of fulfilling the statutory obligations, and should request repeal of the requirements or relief of the obligations. P and C agree with the basic thrust to improve the management of Medicaid. However, we need to evaluate the specific request for additional slots in conjunction with other requests within the Department.

ISSUE: What changes are essential in Medicaid eligibility to improve the management of the Medicaid program? Should legislative changes in Medicaid eligibility be proposed at this time? What changes in Medicaid eligibility are desirable to reduce inequities?

BACKGROUND: The processes and policies relating to Medicaid eligibility were largely neglected from the inception of the program in 1965 until the enactment of P.L. 92-603. The Social Security Amendments of 1972 introduced dramatic changes in Medicaid eligibility in attempts to remove certain Medicaid notches and to conform with the establishment of the new Supplementary Security Income program (SSI). States were permitted to establish eligibility for Medicaid which could be considerably independent of eligibility for cash assistance.

The policy questions raised by the changes in Medicaid eligibility are so complex that major policy issues remain under review almost three years after the enactment of P.L. 92-603. The absence of policy guidance has resulted in inadequate technical assistance provided to the Regional and State Medicaid eligibility staff and the failure to monitor State compliance with current Medicaid eligibility law. States are proceeding independently, without benefit of assurance that their eligibility practices and policies are in compliance. Millions are incorrectly being provided assistance or being denied assistance. If preliminary QC tests are valid, as many as five million individuals currently receiving Medicaid may be ineligible for such assistance. Most likely, an equal number are not receiving the assistance that title XIX requires.

The need for reform of Medicaid eligibility criteria is apparent by the length of time it takes to develop Departmental policy; the lack of understanding by the State agencies of existing policies, and the inability of these State agencies to administer even the provisions they do understand. A considerable proportion of the $325 million spent on Medicaid administration, and of the 20,000 State Medicaid employees, are involved and frustrated by Medicaid eligibility policies and procedures.

Establishment of simplified national Medicaid eligibility criteria would assure that Federal funds were being spent in a uniform manner for the basic health needs of the poverty population, and would facilitate State administration and Federal monitoring.

Measures to simplify Medicaid eligibility requirements would almost automatically become measures to remove inequities in Medicaid eligibility.

A few of the inequities and complexities of the Medicaid program are:

.... In States without medically needy programs, individuals and families with even one dollar of countable income in excess of the cash assistance programs are ineligible for any Medicaid assistance (a potential loss, in actuarial terms, of $950 a year per family): in States with medically needy programs, families or individuals may spend-down their excess income on their own medical expenses and then receive Medicaid assistance.

.... Families and individuals with identical incomes, ages and disabilities are eligible or ineligible for Medicaid depending solely on their State of residence.

....The statute discriminates against intact families, single individuals and childless couples who are ineligible for Medicaid no matter how low their income, unless they are disabled or, in some instances, in some States, unemployed heads of families.

.... Section 209(b) of P.L. 92-603 was enacted to protect States from increases in Medicaid costs which appeared to result from the anticipated huge increases in the SSI rolls. While information on State decisions are (incredibly) still not adequately available, it appears that many of the States, where the eligibility standards were changed most dramatically, have not invoked their 209(b) privileges, while others have embarked on administratively complex and expensive routes separate from SSI, as questionable insurance against possible eligibility increases.

OPTIONS: (1) Retain current Medicaid eligibility requirements and hope that NHI will replace Medicaid with a program with more feasible administration.

(2) Undertake a reform of Medicaid eligibility which will result relatively soon, in reducing the complexity and removing some of the inequities.

RECOMMENDATIONS: The Administration cannot afford to delay reform of Medicaid eligibility until the implementation of national health insurance. The current Medicaid eligibility functions are almost not administrable. The results are that Medicaid can not serve as an advertisement for a Federal/State program of medical assistance or as a model for an income tested health insurance program.

SRS recommends that the Department sponsor discussion of legislative reforms of Medicaid eligibility to remove the complexities, to reduce the inequities, and conform to current interpretations of priorities for medical assistance. Submission of legislative proposals in a reasonable period of time would permit enactment and implementation by mid-1976. P and C agree to a reappraisal of Medicaid eligibility. We would, however, note that (1) Medicaid and welfare eligibility are very much interrelated and (2) most changes in eligibility designed to rectify existing inequities and complexities are likely to entail added budget outlays.

ISSUE: What measures should be undertaken to improve the control of Medicaid costs?

BACKGROUND: Over the past eight years, Medicaid costs have increased four fold, from $2.5 billion in 1967 to $12.4 billion in 1975. Most of this increase is attributable to the increases in the prices paid to the providers of medical services and in the increases in the numbers of eligibles for services. Almost two-thirds of these expenditures have been for institutional care. Some of this has been unnecessary; some has been inappropriate.

The increases in costs have created concern by the Federal and State governments, and by other competing purchasers of medical care services. Demands have been generated for measures to control the rates of inflation in medical care costs, to provide incentives for efficiency and economy and for reduction in the utilization of inappropriate and expensive health services. Most of the measures to improve Medicaid management are similarly measures to control Medicaid costs.

Some of the measures which are being considered and being undertaken include:

1. Utilization Control -
   a. Development of PSROs to review the necessity and appropriateness of medical services;
   b. Implementation of new UR regulations;
   c. Development of provider and patient profiles and other automated surveillance and utilization review measures;
   d. Implementation of the 1903 (g) requirements to reduce FFP for failures to maintain adequate UR systems. Conduct validation surveys.
   e. Development of and encouragement to more economical medical care programs, such as preventive health services and case management in EPSDT, HMOs and capitation arrangements, and alternatives to institutionalization

2. Financial Reviews - assuring the appropriateness of FFP for Medicaid, including whether adequate measures have been taken to assure that third party resources are tapped before Medicaid funds; that State administrative costs are appropriately matched; that physician reimbursement is within the limits for prevailing charges.

3. Reimbursement -
   a. Implementing the requirement of reasonable cost related reimbursement of nursing homes, assuring in that regard that uniform charts of accounts and cost reports are obtained. (Consideration is being given to recommending delay in the implementation of the cost related reimbursement.)
   b. Prospective reimbursement; particularly to hospitals;
   c. Capitation arrangements, both on a State-wide basis and in HMOs;
   d. Monitoring against fraud and abuse.

4. Personal Needs Allowances - to develop a system of control of personal needs allowances (a possible $300 million per year) to assure that these funds are used for the purposes for which they are intended, that they are made available to the patient, that the services for which they were intended are accessible to the patient, and that the patient is not charged out of her personal needs allowances for services which are also being paid for by the Medicaid program.

CAUTIONARY NOTES: While each of these measures are being presented as measures to control the costs of Medicaid, there are a number of points which should be emphasized:

1. They will all require considerable investment of staff and other resources. The savings from these activities may be aprtially offset by the increased administrative costs of conducting these programs. (See management improvements issue paper.)

2. These programs are intended to assure that the care paid for by Medicaid is the most appropriate to the needs and conditions of the Medicaid eligibles. It is highly likely that more appropriate care may not be less expensive financially. Furthermore, the development of alternatives to expensive care may generate demand for these services which may increase total Medicaid costs, although improving the quality of care.

3. Safeguards must be introduced to assure that prospective methods of reimbursement and capitation arrangements do not reduce the availability or the quality of services provided Medicaid recipients. These arrangements have built-in financial incentives which may require close monitoring.

SIGNIFICANT PROGRAM DECISION ISSUES

A. Management Improvements
   - Regulations, Compliance and Sanctions
   - Performance Monitoring
   - Fraud and Abuse

B. Cost Control
   - Utilization Control
   - Third Party Payments
   - Reasonable Cost Related Reimbursement

C. Eligibility
   - Improvements in Management
   - Removal of Inequities

D. EPSDT

E. Long Term Care
   - Organizational Arrangements for Long Term Care
   - Medical versus Domiciliary Care
   - Personal Needs Allowances

A. Management Improvements

Regulations, Compliance and Sanctions

Performance Monitoring

Fraud and Abuse

ISSUE: Can the way regulations are written and enforced be made more effective, including the provision of more effective fiscal sanctions?

BACKGROUND: One of Medicaid's major problems is that States do not consistently abide by Federal program regulations. State non-compliance has become visible and controversial in certain areas like EPSDT and eligibility, but it is a problem across the whole gamut of program regulations. Probably no State program is in total compliance with all the regulations it is supposed to follow as conditions of receiving Federal financial participation.

Examples of important regulations which many States have failed to implement include the spend-down mandated by the Social Security Amendments of 1972 (section 209(b)), retroactive coverage, and periodic medical review for Medicaid nursing home patients. Although delinquent States have been informed of their noncompliance, their deficiencies persist. Federal procedures and sanctions for inducing compliance have often been ineffective.

The lack of Federal control over Medicaid contributes to the management problems facing the program. Problems like EPSDT implementation, eligibility errors, and fraud and abuse would be much less prevalent if regulations could be more effectively enforced.

The problems with compliance suggest we look at the way regulations are now formulated and enforced, including the fiscal sanctions available. There are three main questions to be asked:

First, are the regulations too numerous and detailed? There are some 73 program regulations for Medicaid. Many of them are very detailed, governing the most minute aspects of State programs. Some, notably those for eligibility, are so complex that very few State and Federal officials can even understand, let alone enforce, them. Others, while not detailed, may be peripheral to the main objectives the Department has in regulating the States. Although much of the detail is mandated by provisions of the Medicaid law, some is not. It is worth asking what requirements could be eliminated without endangering the most important Federal goals for Medicaid.

The number and complexity of the regulations make them difficult to enforce. First, the demands that the regulations make are many and difficult. Complete compliance in the strict sense is probably impossible, and the Department has never required it. Second, once some regulations are not enforced, it becomes unclear which regulations are really mandatory. This makes it difficult to insist on compliance in a particular case.

Second, why are the ways we now enforce regulations ineffective? By itself, the existing regulations and compliance system might be made to work. But in practice MSA rarely has the political and legal leverage necessary to enforce its requirements on the states. Initially, the problem appears as one of choice: if the leaders chose to invest the political and administrative resources, the regulations could be enforced. But then the question arises why the political and administrative expense of enforcement is so great.

One reason is that the procedures MSA must use to enforce regulations are very cumbersome. The agency does dispose of financial penalties for noncompliance (see below), and Federal auditors do enforce compliance with many regulations. But in practice, sanctions involving fiscal penalties have been ineffective because they cannot be applied without lengthy compliance and court proceedings.

While the States have the staff and information necessary to run their programs, MSA lacks the resources even to check on State surveillance of regulations adequately, much less monitor State actions in detail. The administrative and time costs of enforcement are so great that States are in a position to bargain with MSA and escape penalties except in flagrant cases.

Another factor is that States, quite naturally, exert their political influence in Congress to deter the Department from imposing penalties or to cause delays.

Only two regular compliance hearings have been undertaken by MSA since the present procedures became effective in December 1969. MSA is typically reduced to administrative methods such as persuasion and technical assistance. Although compliance with individual regulations can be obtained, compliance with all is, in practice, unattainable.

The States are left, on the whole, to monitor their own compliance with Federal regulations. This means that many Federal requirements are inevitably enforced or not according to State perceptions. The legal, administrative, and political forces favoring the States give them the power to follow their own interests and run their programs in their own way.

To redress the balance would require that MSA possess strong legal and political sanctions to overcome the advantages of the States. This raises a third question:

Third, are the financial sanctions available to MSA sufficient? In the case where lesser suasions fail, MSA must be able to enforce compliance with financial penalties. The

penalties now available are not only difficult to enforce, but conceived mostly for very specific and limited purposes. Present law provides that one percent of a State's AFDC matching funds will be deducted if it fails to implement either EPSDT or the family planning provisions of P.L. 92-603. The Medicaid Utilization Review penalty provides that unless the State has a UR system approved by the Secretary, FFP will be reduced by 1/3 for patient stays in hospitals or nursing homes beyond specified lengths.

For non-compliance in other areas, the agency is legally able to withhold all or part of FFP, according to what proportion of a State's program is out of compliance. But this threat has not been credible in the past because of the harm that would be done to recipients, as well as the political resistance of the States and the delays imposed by compliance procedures. To penalize States for not implementing programs and, therefore, not spending Federal money, rather than for spending money inappropriately, has been especially difficult. These factors have made it difficult to use even the specific penalties mentioned above. The Department would benefit if it disposed of additional sanctions which could be used in any area of noncompliance, with graduated penalties, and with fewer enforcement difficulties than now.

OPTIONS: The question is whether to simplify the regulations and seek a more effective way of enforcing them, including more effective financial penalties. These objectives are linked: simplified regulations would both permit and require new and improved enforcement methods.

I. A simplification of regulations could be justified first of all, on practical grounds. Some of the regulations, and details of others, have not proved critical for achieving the purposes of Medicaid. They might be abandoned without endangering the essential Federal goals for the program.

Another argument is that resistance from States is itself an argument for reassessing requirements. Since the States have broad goals for Medicaid which resemble MSA's, their views on which regulations are necessary deserve careful consideration. Their views should be considered at the legislative stage first, so they will feel less motive to disagree with the regulations which will later implement the law.

A rationale can also be drawn from the theory of revenue-sharing, or the "New Federalism": there should be a rational division of labor between Federal and State governments in social programs, with the former setting broad policy and the latter deciding how to implement it. Regulations,

then, should define and protect only the most important Federal interests, and leave administrative details to the States. A recent example of this approach is the new Title XX and regulations for social services.: objectives for social service programs are stated in the law, but the exact choice of services and details of how to administer them are left to the States. It remains to be seen, of course, whether to grant the States this much freedom is, in fact, consistent with obtaining Federal objectives.

The guts of simplified regulations would undoubtedly be definitions of eligibility, the services to be provided, and minimal administrative procedures to prevent overspending (e.g., fraud and abuse). The requirements imposed on States should be strategic, so that lesser Federal interest will be protected also, even though they are no longer stated in regulations. For instance, a well-drawn, simplified eligibility regulation should not only prevent ineligible recipients, but work to restrain the overspending and fraud which now occur, in part, because eligibility rules are so complex.

However, the regulations must still be definite about compliance requirements, in spite of being less detailed than formerly. A lot of present detail serves a necessary purpose; it is there to make requirements specific. The detail cannot routinely be enforced, but it is necessary to make regulations ultimately enforceable in court. One way to make regulations specific with less detail would be to key them to empirical indicators which would show, just as clearly, whether the States are following them. An example is the upcoming shift from administrative surveys to a survey of recipients as a way of determing if States have provided eligibles with EPSDT information, screening and treatment. These indicators would, like administrative requirements, be measures of process or program input -- essentially, a State's level of effort.

A more radical step would be to define compliance in terms of output measures -- that is, measures of program impact on the target population. The measures would probably indicate levels of morbidity and mortality in the Medicaid population or parts of it. To define compliance in these terms would require, in the EPSDT example, not simply information and services to eligibles (as determined by the recipient survey), but reducing morbidity and mortality rates among eligibles to stipulated levels.

Since Federal social programs have traditionally defined State obligations in input, not output, terms, such a change would be a radical step. There would be strong State resistance, and the change would probably have to be authorized by legislative changes. There would be the methodological problem of finding ways to measure output which were able to distinguish the impact of a State's program from other

influences. On the other hand, Congressional interest in evaluating many social programs for impact already indicates some acceptance of the idea that programs should demonstrate performance in output terms.

These are the basic options for simplification of the regulations, in order of severity and with the arguments for each:

1. Keep the regulations as they are: The present level of detail contributes to the general enforcement problem, but empirical measures could not be found to replace it as a way of making regulations specific. Much of the detail is also mandated by the law or the political will of Congrss.

2. Simplify the regulations so they protect only the most important Federal interests, such as eligibility, service provision, and cost-control requirements. Empirical measures could be found to replace administrative detail as clear compliance criteria. Regulations that are simpler could be enforced with less discretion, administrative cost, and political opposition.

3. Use output measures to measure State performance directly and dispense as much as possible with administrative process stipulations. This presumes indicators can be found which really measure State achievement of Federal goals and which are politically acceptable to the States and Congress.

II. Better enforcement methods require that additional forms of leverage be found to exert on the States. As mentioned, MSA's present, largely administrative approach to compliance lacks the basic weight to influence the States, who possess independent political influence and administrative preponderance under Medicaid. While we now monitor selected regulations closely and provide the States technical assistance to improve compliance, the degree of enforcement obtained is poor. These methods, however, minimize administrative costs to MSA and political opposition from the States.

A reform of enforcement methods must either try to strengthen MSA's bureaucratic authority, or it must seek to counter the States' political methods of resistance in their own coin.

To strengthen MSA's authority over the States basically means to allow it to employ sanctions against the States with less check by the courts and Congress. In the case of Congress, the problem is political. Although MSA always acts by authority delegated by Congress, Congress often resists individual attempts to enforce penalties. If MSA seeks a closer understanding with Congress about the purposes of Medicaid, it may be allowed to impose sanctions more broadly. On the other hand,

the Bureau might, in return, have to concede Congress primacy on many policy issues where we have often disagreed. For example, MSA would like to simplify eligibility rules, on grounds of equity and administrative simplicity, but Congress would insist on viewing the present complexity as a way of allocating Medicaid resources to the groups it considers most in need.

In the case of the courts, the problem is legal. The force of the sanctions MSA has on the books is much weakened by the complex, time-consuming compliance procedures necessary to enforce them. Changes in law and regulations to shorten these procedures and give MSA (or SRS or HEW, which have legal responsibility) more power to act on its own authority would give our sanctions much more weight. On the other hand, to propose this would be unpopular with the States and Congress. MSA would have to exercise any new authority very carefully to avoid political backlashes.

Another approach would be to use against the States the political tactics they have used to resist sanctions. Essentially, this would mean seeking to generate much greater publicity about State non-compliance, so that public opinion would either force reforms by its own weight, or allow penalties to be imposed. An example is the FDA, which publically announces when its food and drug standards have been violated, in order to bring political as well as legal pressure against the offending companies. In a controversy, MSA would have the advantage that the reasons for its stance (service to children and the poor, public economy) are politically attractive, while those of the States (practical and administrative difficulties in meeting the demands of regulations) are more difficult to defend in public. The Bureau might win more battles with the States if it publicized and politicized issues instead of pushing them quietly at the administrative levels, where the States have an inherent advantage in resources. On the other hand, for the Department to engage openly in politics over compliance issues might be viewed as illegitimate and draw Congressional opposition.

Part of the rationale for this tactic, as for simplifying the regulations, is drawn from New Federalism theory. As the Federal government gives the States more discretion in running social programs, it also makes them more accountable to their citizens. The States would have to take responsibility more openly for decisions in social policy. The political forces which lobby to influence programs like Medicaid would begin to shift their focus from Washington to State capitals. This means that State governments would be more vulnerable to politicized enforcement tactics than before.

One way to pursue the political tactic would be to hold more compliance hearings in the States. Just as Congressional committees hold local hearings to expose the shortcomings of Federal policy, MSA can hold them to expose noncompliance in

Medicaid. On the other hand, the administrative and political costs of mounting the hearings and sustaining them in the face of controversy would be high, and only a part of costs would be recovered through any penalties levied. A recent legislative proposal of Sen. Percy, S 3503, gave the Secretary explicit authority to hold ongoing oversight hearings in all States, although the procedures to do this for Medicaid are essentially available already.

Options for new approaches to enforcement include the following -- not mutually exclusive -- with the reasons for each:

1. Continue the present methods: Limited monitoring and technical assistance minimizes political and administrative costs. Congress would resist giving the agency more authority, and the States would defeat any attempt to orchestrate national and local public opinion against them.

2. Seek greater authority for MSA through closer understanding with Congress: The agency would obtain greater permission to move against delinquent States, at the expense of ceding greater control of policy to Congress and the committee staffs.

3. Seek greater authority for MSA through legislative change to permit the agency to impose penalties with fewer procedural restrictions than now. While this option would meet opposition and pose political dangers to the agency, it would fundamentally strengthen the sanctions the agency now possesses.

4. Adopt a political approach to enforcement, by publicizing noncompliance and seeking to mobilize public and interest-group opinion against delinquent States at the Federal and State levels. One method would be on-going compliance hearings in the States. This option would allow MSA to answer the States with their own tactics, although at some risk of involvement in controversy.

III. Stronger financial penalties are necessary to enforce compliance if lesser sanctions fail. Present penalties are inadequate not only because of lengthy compliance procedures, but because of their form. As mentioned, the sanctions set out in the law all address specific forms of noncompliance. The option of denying all or part of FFP for unspecified forms of noncompliance has never proven a credible threat because of State ability to resist.

But SRS-OGC has just confirmed in a ruling that the agency does have the authority under existing law to deny partial amounts of FFP, according to the proportion of a State's program that is out of compliance. This approach would allow MSA to enforce compliance wherever necessary,

and to vary the weight of the penalty according to the degree of delinquency and the political realities. The Department should consider using this weapon more resolutely than in the past. Regulations might be changed to make clearer that this sanction is available and will be used. On the other hand, the administrative costs of determining and defending variable penalties would be high, and the prospect of widespread denials of FFP might provoke severe opposition from Congress as well as the States.

Another possibility would be to introduce a new, targeted penalty which would deny FFP for administrative costs to State programs that were out of compliance. Such a sanction would specifically penalize the administrators of the program who are responsible for noncompliance; there would be less risk of damage to the recipients than with other penalties. On the other hand, the amount of money lost might not be sufficient to force improvements in compliance. Further, higher-level officials than the Medicaid administrators may be responsible for the non-compliance, and to deny funds to the latter may actually reduce their ability to live up to Federal requirements. Finally, to institute such a penalty might require changes in legislation, as well as regulations, providing an opportunity for solid State and Congressional resistance.

The options for financial penalties -- not all mutually exclusive -- include:

1. Keep the present penalties: The present sanctions cover the most important MSA concerns. To levy flexible, proportional penalties or institute sanctions against administrative funds would be politically difficult, administratively burdensome for MSA, and might actually reduce State ability to comply with regulations.

2. Levy flexible penalties, to be assessed according to the proportion of a State's program that is out of compliance. While this option might be open to legal or political challenge, it would supplement the issue-specific penalties and allow MSA to penalize non-compliance in any area.

3. Institute a penalty levied against administrative matching funds: This option would penalize the State administrators who are chiefly responsible for non-compliance, with less risk of damage to the recipients than with other penalties.

ISSUE: What measures should the Medical Services Administration (MSA) adopt to monitor the performance of State Medicaid programs? In addition, should MSA develop extensive capability to provide assistance to States in improving operations?

BACKGROUND:

Problem:

Recent investigations by GAO, by Congressional committees, and by the Executive Branch have clearly documented the existence of operational weaknesses in State Medicaid programs. The easily uncovered problems were extensive, severe, and located in critical program areas. The criticisms have ranged from California's poorly executed attempt to design and implement a major new program initiative, the Prepaid Health Program (a version of health maintenance organizations), to New York's lack of monitoring fraud in nursing homes.

The severity of the inadequate State program management is evidenced by the areas in which problems were uncovered, the magnitude of the uncovered problems, and the ease at which independent investigators uncovered these problems. California and New York are the largest Medicaid States, with a combined total of 31 percent of the total Medicaid budget. HMO's are a major departmental initiative for revamping the health delivery system. Long-term care facilities, which include nursing homes, consumed more than 35 percent of the FY 75 Federal Medicaid budget. Investigators and, in fact, even newspaper reporters quickly uncovered problems in the Medicaid system. Estimates of the total fraudulent or wasteful expenditures ranged from the millions to the billions of dollars.

Federal Management Options:

The Federal role in the Medicaid program could be one of the following:

1. A federalized system similar to Medicare.

2. States possess management responsibility, but the Federal level establishes performance standards, monitors States against those standards, and ties reimbursement to meeting those standards.

3. States administer the Medicaid program and the Federal Government establishes minimal program requirements.

4. State responsibility for the administration of the program with Federal financial participation. This would basically be the relationship of the revenue sharing model.

Barring a major legislative change, the basic management options are either number 2 or number 3. The Department has generally pursued option 3, leaving the States to administer the bulk of the Medicaid program within fairly broad Federal guidelines, reserving option 2, of a more active Federal role, for certain critical program areas. MSA now advocates adopting an extensive, comprehensive monitoring program that would fully implement option 2.

DISCUSSION: The basic issue is whether or not the Federal investment in Medicaid has grown to such an extent that the originally conceived Federal role has become outdated. Originally, the Federal role was to establish basic program guidelines as to what individuals could be covered by Medicaid and what required and optional services should be provided, option 3.

The constraints on the Federal role grew out of Medicaid's historical antecedents and the political reality of 1965. Medicaid was passed as an add-on to the welfare system; the States had always maintained responsibility for providing and managing their own welfare services. A bill with a strong Federal management presence would probably not have passed Congress.

The minimum staff resources assigned to MSA reflect the intended Federal role. At no time has the Central Office exceeded 200 positions; and in fact, is currently operating at a strength of 135, with 190 positions. Medical Services staff in the Regional Offices totals less than 100.

As the Federal expenditure on Medicaid rose from 2.6 billion in FY 70 to 6.5 billion in FY 75, there was a corresponding rise in Federal concern over how well this money was being spent. In areas of high priority, the Federal Government has adopted a strong role of oversight of States. The number of major initiatives, and corresponding involvement includes at present:

----EPSDT - requires States to provide preventive health services for Medicaid eligibles under 21.

----Utilization Control - addresses the utilization of services (primarily institutional) to assure their medical necessity and appropriateness.

----Medicaid Quality Control - addresses the proper determination of eligibility by the States (for those who are not covered by the AFDC-QC program or by the SSA Quality Assurance Program, which covers Medicaid recipients whose eligibility is determined by SSA).

----Provider Fraud and Abuse - addresses fraudulent and abusive practices among providers of Medicaid services through evaluation and monitoring of the States' fraud and abuse surveillance activities. Providers who are benefitting unfairly from the Medicaid program will be both acted against and deterred.

----Financial Reviews - address State financial management of the Medicaid program from the standpoint of assuring appropriate Federal financial participation. As many as 12 different reviews can be applied in each State in order to identify weaknesses, provide technical assistance, and save Federal funds.

----Medicaid Management Information Systems (MMIS) - address, with the aid of increased Federal financial support, improving Medicaid claims processing and information retrieval systems.

Given the present concerns of Congress and the Executive Branch, SRS must continue these initiatives which require significant monitoring of State operational performance but in limited program areas. Therefore, option 3, only broad Federal guidelines, would be unrealistic at this time.

MSA must now decide whether to continue the topical approach to improve State management or to attempt to develop an integrated, comprehensive approach to evaluate and improve State performance. MSA recognizes that, theoretically, the approach of monitoring only special program areas is not an effective, efficient method of fulfilling the Federal role. The topical approach does not deal with a State in a comprehensive, integrated manner and therefore, often fails to address basic issues such as inadequate leadership or resources. Often a State responds to the latest Federal priority by moving critically scarce resources from topic to topic as the Federal focus changes.

A more desirable strategy would be to institute a State performance evaluation system which would:

----Identify the critical program elements of a State Medicaid system,

----Establish criteria for evaluating performance within each of these critical program elements,

----Determine what data are needed to monitor each element, and

----Continuously monitor the performance of all States against the performance criteria for all critical program elements.

While a comprehensive approach would be more desirable than the topical approach, the feasibility of the comprehensive approach is presently unknown. The major questions are:

1. Can performance standards be established? If yes, what should they cover? The monitoring system must be designed to be sensitive to the inter-relationships among the elements of State operations. For example, the claims payment function (bill paying) influences provider participation (the number of doctors taking Medicaid recipients) which in turn influences the health status of Medicaid recipients. The slower the physicians are paid, the fewer physicians participate in

the program. When bills are subjected to closer scrutiny because of a fraud and abuse initiative, the claims payment processing might slow down excessively unless it were also monitored.

MSA is currently determining which program elements can be monitored with output measures and what the inter-relationships among the program elements are.

2. Does the diversity of State programs preclude comparisons? The diversity of size and complexity of State programs precludes every State from being comparable with every other. However, comparison groups can be established and then States can be compared with others within a matched group. MSA is developing a classification scheme that will attempt to sort all States into groups with similar size and program complexity. Performance norms will then be established for each group of States.

3. Does MSA have adequate resources to implement a comprehensive monitoring system covering all States? Between 1967-71, MSA attempted to conduct comprehensive reviews of the management of State programs and found that these reviews consumed a tremendous amount of staff time. To be effective, they drew from the most experienced, knowledgeable personnel, diverting them from operational activities. Shortly after the responsibility for the reviews was transferred to the Regional Offices, the review program was abandoned. The resources which had been allocated to the reviews were shifted to the implementation of the priorities in the operational planning system (OPS) and the reviews ended. To perform on-site, comprehensive reviews of 53 programs would consume approximately 50 person years of effort, far more than currently available for this type of activity.

Since MSA is in the developmental stage of establishing State performance criteria and does not have sufficient resources for a fully implemented monitoring program, MSA has adopted an evolutionary approach for FY 76. During FY 76 MSA will strengthen its monitoring capability by implementing:

----A State Data Book. This is a standard book of data and descriptive information that will be prepared for each State.

----Data flow improvement. MSA is currently working to improve both the accruacy and timeliness of data received from States. In addition, MSA will start capturing program management data as well as statistical research data.

----State assessments. MSA staff will perform periodic, on-site, comprehensive assessments of the operational performance of selected State programs. During FY 76 MSA will focus on the States with the largest expenditures. Since the 10 largest States consume approximately 70% of the Federal Medicaid dollars, a limited staff properly targeted can monitor a large portion of the Federal expenditures.

----Augmented a day-to-day monitoring by MSA and the Regional Office staff.

This increased Federal monitoring effort will also enable elected officials at the State level and citizens to monitor the performance of the State Medicaid programs. Previously, State officials have not had any viable method of learning how well their Medicaid program was run compared to other States. The information obtained from the Federal monitoring will be made available to State officials.

In addition to close monitoring of State programs, another appropriate Federal function is to disseminate information of the "best practices" already developed by individual States. The operational aspects of Medicaid are extremely complex, particularly in areas such as fraud and abuse surveillance, claims processing, eligibility control, and provider relations. It is impossible for each State to keep abreast of all improvements in these areas and assess their applicability to itself. MSA plans to become the depository for knowledge on "best practices." In addition, the close operational monitoring will greatly contribute to MSA's program to identify the best policies and operational practices that currently exist in specific States and to identify which other States would benefit from adopting those policies or practices.

After identifying a number of "best practices" MSA plans to provide individual States with the technical assistance that will help them to adopt these "best practices." Too often in the past, MSA has been able to identify problems within State systems, but has not had the resources to help States find solutions to the identified problems. MSA now intends to hire and train staff who can act as consultants to the States and advise them on the implementation of improved practices. MSA also intends to conduct a series of workshops tailored to the needs of small numbers of States.

OPTIONS: MSA could pursue one of two strategies for helping the States to improve management of Medicaid. It could:

----Continue to focus monitoring and technical assistance efforts on selected high priority topics, or

----Establish performance criteria for all critical operational components of a State system and monitor all States against those criteria. This would involve developing staff expertise for providing States with technical assistance in a number of inter-related program elements.

If it is decided to establish broad performance criteria, then the Department would probably choose an evolutionary approach in which the coming year would be devoted to developing a model of how to perform comprehensive State assessments and applying this model to the largest Medicaid States.

RECOMMENDATION: MSA's basic strategy for improving State management would eventually involve:

----Establishing performance criteria for critical operational components of a State system and monitoring all States against those criteria, and

----Identifying the best program policies and operational practices developed by individual States, identifying which additional States should adopt those policies or practices, and providing technical assistance to States in their efforts to improve their programs.

MSA recommends adopting an evolutionary approach to implementing this strategy. At present neither the knowledge nor the staff exists for immediately implementing these activities. An extensive, crash program would impose an untested control system on all States with the potential of severe negative, unintended consequences. In addition, since a small number of States consume a large portion of the Federal Medicaid expenditures, MSA's scarce resources can most productively be used by targeting them on the large dollar States.

ISSUE: What additional program initiatives can be undertaken to identify, for court action, suspected fraud cases? What would be the budget impact?

BACKGROUND:

Strategy

The recognition that an undefined but significant amount of provider fraud and abuse exists in at least some Medicaid States has caused DHEW to commit significant additional resources to an expanded Federal effort in Medicaid provider fraud and abuse control. The commitment of staff, particularly, is many times greater than it has been in the past.

The FY 1975 appropriation made possible an increase in the Central Office staff from one person to eleven. One hundred and eight new Regional Office positions have been requested in the FY 1976 President's Budget.

The activities that are planned (and outlined below) assume that the requested positions, or a large portion of this request, will be granted. The activities to fulfill the Federal role are based on the additonal assumption that, as in the past, State fraud and abuse control systems will be relied upon to perform the functions of identification, referral and tracking of the suspected cases of fraud. The Federal role will be to assure compliance with Federal regulations on State fraud control systems, and to make available to the States the kind of assistance needed to improve their State systems.

Specific Tactics

The Department will monitor much more closely the State fraud and abuse surveillance activities and will vigorously enforce compliance with each requirement specified in 45 CFR 250.80 (which pertains to provider fraud and abuse surveillance).

We will undertake analysis of the characteristics of State fraud and abuse surveillance and prosecution networks (those include the single State Medicaid agency, State prosecutors, and various judicial jurisdictions) to determine the factors which produce successful control systems.

We will track all cases of fraud through local and State law enforcement networks and thus will be able to pick up and refer to Federal prosecution those cases on which the State declines action. Investigatory resources on program staff will continue to be limited so that we use OIS and Department of Justice investigatory staff on a case-specific

basis in order to prepare cases for prosecution in Federal courts. Our emphasis will be, however, on improving State performance rather than on replacing State with Federal legal action.

We will develop guides which will allow Federal staff to sample from groups of providers (initially from physicians, pharmacies, and nursing homes) and to measure the rates and characteristics of the fraud and abuse detected from examination of their records and practices. We will employ these guides in all States in order to evaluate the effectiveness of the State detection and deterrance efforts and will use the results to motivate States toward more effective performance. In this regard, we will explore the possibilities of the QC approach to monitoring the effectiveness of the State systems for detecting fraud.

We will study and document the success-inducing practices of States with effective systems. The descriptions (best practice reports) that result from these examinations will be distributed to other States in order to encourage the transfer of best practices. Several multi-regional workshops will also be conducted to train State staff and to encourage the transfer of best practices.

We will step up our technical assistance to States, expecially in audit and investigatory practices and techniques.

We will explore the possiblities of requiring the States to develop and maintain provider profiles and patient profiles, in order to facilitate the detection of abnormal practices.

We emphasize that we recognize that the problems are much broader than fraud and its prosecution. Program abuse is probably diverting much larger amounts than the actions that could be prosecuted as fraudulent. We will insist that the States detect abuse as well and subject abusive providers to administrative sanctions such as recovery of abusively obtained reimbursement, suspension and even termination from the program.

Budget Impact

In the absence of an effective network for evaluating the extent of fraud and abuse, we cannot estimate the dollars which have been wasted and diverted from providing necessary medical services for needy eligibles. Accordingly, we cannot estimate the extent of the budget savings which would be achieved through our methods of trying to correct these fraudulent and abusive practices. On the other hand, without effective systems for controlling the abusers, Medicaid will continue to be subject to unfavorable reviews and a generally hostile press. Evidence that public authorities are vigorously pursuing the offenders will be necessary to instill credibility in the Medicaid program's efforts to help low income people to obtain medical care.

B. Cost Control
   Utilization Control
   Third Party Payments
   Reasonable Cost Related Reimbursement

ISSUE: What improvements may be made in the Department's utilization control program? What are the probable costs and savings of changes in utilization control efforts? What staff and organizational arrangements are necessary?

BACKGROUND: The States, the Federal Government and the Medicaid recipients have had an interest in assuring that only necessary medical services are provided under Medicaid, and that surgery, hospitalization and other institutional care are kept to the minimum compatible with adequate health care. Section 1902(a)(30) has required the States to maintain methods and procedures needed to safeguard against unnecessary utilization of care and services under Medicaid. Nevertheless, the General Accounting Office, the HEW Audit Agency, other investigators, and other critics have found evidence of substantial unnecessary and over utilization of costly institutional care, while there existed insufficient use of the less costly alternative healthcare services.

The 1972 Amendments to the Social Security Act contained a number of measures intended to achieve improved patterns of utilization of health care services under Medicaid, including PSROs, Cost Sharing, certain improvements in SNF standards, as well as penalties for inadequate State systems of UR. The latter was contained in Section 1903(g) which was intended to place affirmative responsibility on the States to assure that patients were placed properly in institutions. Federal matching was reduced by one-third in payments for inpatient services for Medicaid recipients, after their stays in such institutions had exceeded certain prescribed limits (60 days in a hospital, SNF, or ICF; 90 days in a mental hospital; during any fiscal year), unless the State title XIX agency was able to make a showing, satisfactory to the Secretary, that it has in operation an effective program of control of utilization of such services.

On-site surveys, conducted by DHEW in the first half of FY '75, found many deficiencies in State UR operations, even against the requirements in existence at that time. Regulations require pre-admission review for all SNF and ICF patients, regular review programs in SNFs and mental hospitals, and independent professional reviews in ICFs. More stringent conditions, which would require hospitals to establish systems of concurrent review of admissions and to use norms in determining appropriate lengths of stay, were to have been introduced in FY 76. The ruling by a US Circuit Court, which enjoined the implementation of the new hospital UR regulation, has been appealed. A requested stay of the injunction has been denied; a substantive ruling is expected soon.

SRS has assigned 130 manyears mostly in the Regional Offices to monitoring conformance with the UR regulations, validating the State "showings" of effective utilization control programs, and assessing State systems considered superior to and thus exempted from the Medicare hospital UR requirements. The staff will also assist the States in developing

corrective action plans; they will explore exemplary UR practices, particularly in the non-institutional care areas, with a view toward extending the UR efforts in these fields to States whose practices need improving.

ISSUE 1: What organizational arrangements are necessary to improve the implementation of the Federal UR strategy in Medicaid?

BACKGROUND: The Medicaid UR efforts of a very limited character were originally located in MSA in the Central Office and in MS units in the Regional Offices. As an indication of the utmost importance to which the Administration assigned these efforts, the Division of Utilization Control was established in the Office of Special Initiatives in the Office of Management in the Office of the SRS Administrator; most of the Central Office UR functions were transferred to this unit. As of July 1974, 100 staff positions were added to the Special Initiative Units (SIU) (not the Medical Service Units) in the Regional Offices to carry out the UR activities.

The Central Office Division of Utilization Control was transferred back to MSA in January 1975, and these 25 positions represent the only UR staff directly responsive to Medical Services direction, guidance and priorities. The rest of the UR staff remains in the SIUs in the Regional Offices, where they are also engaged in AFDC-QC, Medicaid QC and EPSDT penalty monitoring.

The training and focus of the Regional UC staff tend to be in auditing and financing; their experiences in health, medical care and the Medicaid program tend to be extremely limited, as is their ability to advise and assist the States in developing complex UR systems, and in evaluating State performance against fairly technical standards. The responsibilities of the Regional UR staffs include providing technical assistance to the States in implementing the UR regulations; reviewing and evaluating waiver requests; assessing State UC procedures regarding each item of care and services in the State Medicaid programs; analyzing quarterly "showings" of implementation; assisting States in developing working arrangements with PSROs, including memoranda of understanding; as well as coordinating and reviewing State corrective action plans.

A number of deficiencies have been registered about the UC organizational arrangements. States have complained that the UC emphasis has been on punitive measures rather than assistance, and they have challenged the validity of the Department's evaluation of the State UC efforts. The MS units in the Regional Offices have complained that their relationship with the State XIX agencies has been further weakened by the intervention of another focus of

Medicaid authority; that the priorities for UR efforts have been determined by units unfamiliar with Medicaid program needs. The Central Office of MSA has echoed these considerations, with the added problem that the fragmenting of offices responsible for Medicaid functions reduces rather than enhances the possibilities of information coming to the Central Office.

RECOMMENDATION 1: MSA has recommended that a solution to this problem would be found in assigning at least 50 of the original 100 Regional Office Utilization Control positions to Regional Medical Services staff for FY 1976 UC activities.

ISSUE 2: When should Utilization Control On-site Validation Surveys next be conducted?

BACKGROUND: Section 1903(g), effective July 1, 1973, requires each State to make a satisfactory showing to the Secretary on a quarterly basis that it has an effective program of controls over the utilization of institutional services. Further, the statute requires the Secretary to conduct sample on-site surveys in public and private institutions to validate State's assertions of an effective program. When States are found not to have an effective UC program penalty reductions FFP are to be imposed.

The statute was considered to be self-enacting; two surveys have already been conducted to determine if States are implementing its requirements.

Final regulations implementing the statute were issued to be effective July 1, 1975, but were delayed by court order. These regulations were prepared to be compatible with title XVIII and the PSRO review format. A number of recent Secretarial decisions impact rather heavily on the further interrelationships of the agencies involved in UR and PSRO activities. Of particular note is the decision, made by the Secretary on May 21 that an Interagency Task Force be established under the Assistant Secretary of Health to look into the several monitoring and validation activities of HEW with a view toward consolidation where practical. The recommendation of this Task Force will affect the timing of the next survey.

Another consideration is the availability of regional SRS Special Initiatives Unit staff to participate in the on-site validation surveys. Currently this staff has the responsibility for: Medicaid QC; AFDC-QC; EPSDT Surveys; and Utilization Control Validation Surveys. The Director, Office of Special Initatives has indicated that the staff will generally not be available for UC surveys until July 1976.

Furthermore, concerns have been expressed that Federal on-site surveys of the implementation process conducted during the first six months of FY '76 would be counter-productive. The court ruling which delayed implementation of the UR regulations has generated confusion within States and institutions. Time will be required to establish confidence and begin implementation. Facilities will then have a substantial amount of work in implementing the more complex UR requirements and in improving the procedures. Similarly, State Medicaid agencies will be heavily involved in implementing and/or refining their UC programs during this period.

Current plans are to have Regional Medical Services staff participate in selected surveys of State agency implementation of the new UC requirements during the first six months of FY '76. However, these limited surveys could not substitute for the sample on-site surveys called for in the statute.

It should be recognized, however, that GAO and the various Congressional oversight Committees have expressed concern that the Department has not exercised sufficient effort to validate the State claims of effective UC programs. This criticism will have to be allayed and any delay would have to be justified to the Committees.

RECOMMENDATION 2: Plans be made so that the sample on-site validation surveys in public and private institutions, as required by Section 1903(g) would be conducted in the July through September 1976 time period.

ISSUE 3: What would the Medicaid program savings attributable to improvements in utilization review activities?

BACKGROUND: The utilization control measures contained in the Social Security Amendments of 1972 were introduced as a means of improving the patterns of utilization of care under Medicaid and as a means of controlling the increases in costs. It was assumed that there was considerable over-utilization of institutional care, that the UC systems in the States were largely ineffective in preventing this over-utilization and that considerable savings in expenditures would be achieved with the implementation of the penalty. In general, it was assumed that States would not want to be subject to the penalty reduction in FFP, but would instead improve their UC systems to remove the instances of improper over-utilization.

On the basis of extremely limited information, assumptions were then made about the proportion of stays which were unnecessary, the proportion of patients who could be transferred to lower levels of care or sent home, and the differences in expenditures (or savings) which would result from the States taking these appropriate UC actions. In fact, it was originally estimated that the savings or cost avoidance in FFP would amount to $157 million in FY 1975 and $160 million in FY 1976. It was assumed that the States would save or avoid spending a similar amount.

On the basis of a very rough survey, to which 33 States responded, the original projection of FY 1975 was revised downward to $88 million. The revision was based on State estimates of denials of admissions and extended stays, and of transfers to lower levels of care. The survey has generated a number of questions concerning the original estimates, as well as any estimates which could be undertaken at this time.

1. The original assumptions about the impact of UC efforts were probably invalid. As a minimum, they did not take account of the increased costs of conducting UC programs; such administrative costs might offset much of the savings in medical care expenditures. Furthermore, they did not acknowledge that UC might reveal deficiencies in care, and therefore result in increases in services and consequent increases in costs.

2. The transfers of patients to "lower" levels of care may not achieve savings to public welfare programs. The differences between SNF and ICF costs may not be sufficient to offset the extensive UC review and transfer costs. The transfers to home health and other alternatives to institutionalization may involve substantial increases in maintenance and even medical care costs. (See discussion of Alternatives to Institutional Care.)

3. The State data needed to determine cost savings and avoidances are currently extremely limited in availability and of doubtful reliability. A methodology for collecting and aggregating the necessary data will have to be devised, and then time and resources will be needed to implement it.

4. The original estimates assumed that cost savings would vary directly with program expenditures, and therefore that savings would increase over time. It is probably more reasonable to assume the opposite and that once effective UC systems are introduced, savings will decrease or at least level off, over time.

To overcome some of these problems, research contracts have been undertaken to determine if cost savings and/or cost avoidances could be attributed to UC or its subparts (UR, MR, IPR); and to develop a methodology by which States can accurately determine cost savings and/or cost avoidances.

RECOMMENDATION 3: That the Department refrain from issuing statements concerning the amounts of expenditures which will be saved or avoided, until mid FY 1976 when the research findings will be completed and efforts to develop a more reliable data base will be in place.

ISSUE: What program initiatives should be undertaken to increase third-party payments to offset Medicaid costs? What are the possible budget impacts of these measures?

BACKGROUND: Section 1902(a)(25) requires States to make all reasonable efforts to utilize third party resources in payment of title XIX costs of services incurred by recipients. The section was added by the Social Security Amendments of 1967 in recognition of the value of third party payments in rducing Medicaid costs. The Department has issued a regulation implementing the Amendment; a draft guideline is still in preparation.

In general, the States have not reigorously implemented a program of recapturing third party resources. Their low performance has been attributed to the lack of staff and to the absence of persistent Federal policy. A recent GAO study revealed that about 25 States report no collection of third party liability funds; the other 25 States report collections totalling $12.5 million per year.

GAO has concluded that an additional $12.5 million per year could be saved if the States with no third party recapture programs were to achieve the same success as those who already have such programs. This estimate did not take account of the relative sizes of the programs without third party search activities, nor did it account for any differences which might result from additional costs of collection, litigation or administration in the non-conforming States. GAO's optimistic estimate can be appreciated, however, when it is learned that if the experience of Washington State, which has a rigorous program of recapturing third party payments, were to be replicated in all of the Medicaid States, the total Federal and State savings would approximate $100 million a year.

Beginning in 1974, some attention has been focused on the problem. First of all, GAO plans a review, in the summer of 1975, of third party liability efforts in California, Oregon, Washington, Maryland, Nevada, Virginia and Texas.

Secondly, the HEW Audit Agency in Region III prepared an audit guide for studying claims processing. The guide examines third party liability questions as well as eligibility, provider payments, reasonableness of costs, provider profiles, recipient profiles. There is some question, however, whether the third party liability portion of the guide will be applied when the study is implemented.

Thirdly, SRS/AFM, Division of State Grants Administration has contracted with Touche-Ross and Co. to prepare a financial management guide on third-party liability. Plans have been made for the SRS Regional FM Divisions to use the guides in 1975 in 18 States and jurisdictions (Massachusetts, New Hampshire, Vermont, Puerto Rico, Virgin Islands, Pennsylvania, West Virginia, Indiana, Michigan, Minnesota, Wisconsin, Louisiana, Texas, Montana, South Dakota, California, Hawaii and Nevada).

RECOMMENDATION: If the activities concerning third party liability for Medicaid payments are completed, by the end of calendar year 1975,

there should be a relatively reliable body of information on the extent and nature of third party coverage of Medicaid recipients and the measures which can be taken by the States to recover such funds. It is recommended that the Department indicate the importance that it attaches to completing the studies now underway, and that staff and resources be assigned to assure their completion. As soon as possible, model practices should be identified, and this information should be disseminated to the States.

ISSUE: Should the Administration propose a delay or repeal of the requirement that States reimburse nursing homes on a reasonable cost related basis?

BACKGROUND: The Social Security Amendments of 1972 established Section 1902 (a)(13)(E), which stated that, effective July 1, 1976, State plans were required to provide "for payment of services in SNFs and ICFs on a reasonable cost related basis, as determined in accordance with methods and standards which shall be developed by the State on the basis of cost-finding methods approved and verified by the Secretary."

The Finance Committee Report accompanying this section expressed concern that, under the current reimbursement systems, some ICFs and SNFs had been overpaid by Medicaid, while others were being paid too little to support the quality of care that Medicaid patients are expected to need and receive.

The Report continued that it expected that the State systems would be flexible enough to prevent windfall profits and unjustifiably low payments, luxury service payments and questionable allowances for depreciation. One goal of introducing the reimbursement systems would be the achievement of simple and reliable financial records and adequate procedures for auditing.

On the other hand, the Report emphasized its concern for the Medicare reimbursement methods which were detailed, cumbersome and expensive. It suggested, therefore, that Medicaid systems should not necessarily be patterned on existing Medicare reimbursement methods, and in fact that Medicare methods might be adjusted in instances where the State Medicaid methods contained superior elements.

MSA has been actively involved in the preparatory steps which are necessary for the Department to issue the regulations implementing, by July 1, 1976, the State plan requirement on reimbursing nursing homes. Significant issues have been identified, various methods of resolving them have been considered, and in many cases, draft Departmental positions have been recommended. These actions have been taken after extensive consultations with other areas of the Department, particularly H, P and SSA; with provider groups; with academic and professional experts in long term care and reimbursement; with State budget and economic officials: and after conducting workshops in the subject at the recent annual meeting of the State Medicaid Directors.

The most significant areas which require resolution are: allowances for depreciation, including the value of sold or transferred assets; allowances for a reasonable return on equity capital of proprietary facilities (profit), bad debts, occupancy levels, cost apportionment and uniform chart of accounts and

and cost reports. (Details of these issues are contained in MSA reports.)

The many conflicting objectives have almost defeated the possibility of achieving acceptable solutions. On the one hand, there is concern that the State system should be required to yield rates which would be adequate for homes to meet the increased standards of nursing home care and to retain and attract nursing homes of appropriate quality. On the other hand, the States want to protect themselves against cost escalation. Many of the States have complained that the joint Federal actions of enforcing the upgrading of nursing home standards while allowing providers to pass on the added costs of implementing these standards would place an excessively heavy burden on State Medicaid programs. The Federal government is similarly concerned with the inflationary implications of a cost related reimbursement system, particularly at this time.

The issue of return on equity capital has generated considerable controversy. Many States have asked that the Federal regulation help them to resist the local pressure for profits that were independent of equity capital, economy or efficiency. In possible contradiction, Senator Talmadge stated that he intends to introduce legislation which would require that State reimbursement methods contain profit margins in Medicaid nursing homes. (The details of this proposal are not yet known.)

OPTIONS: The Department appears to have three options with regard to the regulations on reasonable cost related reimbursement to nursing homes.

Option 1: The Department should proceed with deliberate speed to complete the procedures necessary to issue a regulation which would be effective July 1, 1976. The Department and Administrative procedures for issuing so significant and controversial a regulation as this one would consume all of the remaining year.

PRO: (1) This action would implement the statute and Congressional intent.

(2) The regulation would make it possible to achieve the purposes of the statute, namely to obtain a rate of reimbursement which would be adequate to support the quality of care needed by Medicaid recipients and which would yield a system of reliable financial records.

CON: (1) The issues generated by the issuance of the regulation will not be readily resolved. The controversy surrounding these issues is bound to create hostility of whichever sectors feel that they have been inequitably or improperly treated -- either Congress, States, non-profit nursing homes, proprietary nursing

homes, recipients or public action groups.

(2) In the current absence of reliable cost records in nursing homes, it is extremely difficult to estimate the cost implications of the introduction of reasonable cost related reimbursement rates. Some of the States are already using a reasonable cost related formula. Other States are paying negotiated rates which appear to yield sufficient return to nursing home operators that homes are being maintained and there are no shortage of facilities, at least at current levels of standards enforcement. For the other States, the new reimbursement rates would probably yield increases in reimbursement of some unpredictable magnitude. These increased fiscal burdens would be difficult to assume at both the State and Federal levels at this time.

Option 2: Delay issuing the final regulation until more reasonable resolution of the conflicting positions can be achieved.

PRO: (1) The Department would be attempting to implement the intent of Congress, while trying to achieve reconciliation of the many conflicting interests.

(2) The inflationary impact of the regulation would be delayed for some time.

CON: (1) The advantages of the regulation (reasonable reimbursement, adequate quality care, reliable financial records) would also be delayed for some time.

(2) The conflicting interests in this regulation are too fundamental to be compromised in any reasonable period of time. The Department will be accused of delaying tactics.

Option 3: Propose legislation to delay or repeal the requirement that States reimburse nursing homes on a reasonable cost related basis.

PRO: (1) The Department could justifiably maintain that the current economic situation, the additional enforcement activities, and the tremendous controversy which surrounds this regulation were not anticipated at the time that the amendment was enacted. These conditions would all warrant more reasonable delay in implementation.

(2) If the legislative proposal is successful, the delay would avert much of the controversy and would delay the inflationary impact of the measure.

CON: (1) The Administration's proposal would alienate those groups who sought the reasonable cost related reimbursement methods. If the Federal government abstains from introducing the delay

proposal, perhaps some States would assume that political burden.

(2) The advantages of the proposal would be delayed or lost.

RECOMMENDATION: That the Administration explore the possiblities of proposing, or getting other interested parties to propose, a delay in the implementation of the measure. At the same time, the Administration should press for uniform chart of accounts and cost reports.

C. Eligibility
Improvements in Management
Removal of Inequities

ISSUE: How can reform of Medicaid eligibility criteria result in improving Medicaid program management?

BACKGROUND: Historically, the Legislative and Executive branches have attempted to improve the management of the Medicaid program by imposing requirements on the State agencies administering the Medicaid programs and on the providers who participate in the program. The potential for improving program management through reform of basic eligibility criteria has been virtually unexplored. The few program initiatives in the area of eligibility have been limited to the process of eligibility determinations -- as in the early experience of simplified eligibility forms and the more recent SRS Medicaid QC program -- instead of more fundamental program reforms.

The processes and policies relating to eligibility have been neglected since the inception of the program in 1965; basically, this lack of attention derived from the location of the Medicaid eligibility policy function in the SRS cash assistance bureau. Only within the last three years, has the situation changed, as a result of a number of events:

1. The enactment of P.L. 92-603 (the Social Security Amendments of 1972), which established the SSI program and made major changes in Medicaid eligibility criteria and options.

2. The transfer of the Medicaid eligibility policy function from APA to MSA in 1972. The changes introduced by P.L. 92-603 made the separation of Medicaid eligibility policy from MSA no longer tenable.

3. The implementation of the SSI program by SSA, which established for the Medicaid program new eligibility criteria and processes.

4. The Congressional and Administrative interest in ineligibility rates for all public assistance programs, and the resulting establishment of quality control programs by SRS for the AFDC and Medicaid programs and by SSI for the title XVI program.

As noted above, P.L. 92-603 made major changes in the Medicaid eligibility criteria and in the options available to States. The two most major changes may be summarized as follows:

----The eligibility requirements for SSI replaced those of the cash assistance programs for the aged, blind and disabled (titles I, X, XIV, and XVI).

----States were no longer required automatically to provide Medicaid coverage for all aged, blind and disabled cash assistance recipients but could, instead, retain their January 1972 standards or establish any other standard which was more liberal than the SSI standard. If States opted not to cover all SSI recipients, they were required, however, to institute a spend-down similar to that in effect for the

medically needy programs (regardless of whether or not they also had a medically needy program).

DISCUSSION: The policy questions raised by the changes in Medicaid eligibility are so complex that SRS policy on such changes in large part has not been finalized. Major policy issues remain "under review" almost three years after the enactment of P.L. 92-603. This absence of policy guidance is due to several factors:

1. The extreme complexity of the statutory Medicaid eligibility provisions.

2. The absence of specificity of Congressional intent for many of the above provisions.

3. The cumbersome and inadequately staffed SRS policy clearance system.

4. The requirement that Medicaid eligibility incorporate some but not all of the eligibility policies established for the cash assistance programs, which are administered by SSA and APA.

The absence of policy guidance has resulted in inadequate technical assistance provided to the Regional and State Medicaid eligibility staff and the failure to monitor State compliance with current Medicaid eligibility law. As a result, States are proceeding independently, without benefit of assurance that their eligibility practices and policies are in compliance. Most important, millions of individuals are being denied assistance, or incorrectly being provided assistance. The SRS Medicaid QC staff have estimated on the basis of preliminary tests that the ineligibility rate for Medicaid is 20 percent. This could mean that as many as five million individuals currently receiving Medicaid are in fact ineligible for such assistance.

Unfortunately, the SRS Medicaid QC program, while a valid program effort to determine problem areas in the administration of existing Medicaid eligibility policies, misses the larger issue of the need to reform the basic Medicaid eligibility criteria.

The need to reform such criteria is apparent by:

1. The length of time it has taken to develop policy for the issues raised by P.L. 92-603,

2. The lack of understanding of the existing policies by the State agencies determining Medicaid eligibility, and

3. The inability of those State agencies to administer the provisions it currently does understand. In brief, the present Medicaid

eligibility provisions are virtually unadministerable by all but the smallest States with the simplest Medicaid programs. Federal efforts to review such administration will be frustrated by the complexity of the process itself.

Another unanticipated and undesirable side effect of the complex Medicaid eligibility criteria is the existence in most States of huge bureaucracies whose function is to manage the Medicaid and cash assistance eligibility determination processes. The increasing documentation and other staff work performed for each case translates into higher administrative costs which divert program funds from the funding of medical services. It is estimated that for FY 1976, over $325 million will be spent for administrative costs; a considerable proportion of this for eligibility determination.

Establishment of simplified national Medicaid eligibility criteria would not only assure that Federal funds are being spent in a uniform manner for the basic health care needs of the poverty population, but would facilitate State administration and Federal monitoring. States would remain as free as they are now, to supplement the basic Medicaid program by assisting additional groups under State-funded programs.

ISSUE: What changes in regulations and statutes are desirable to correct some of the inequities of Medicaid eligibility? Should measures be taken to correct Medicaid notches? Should steps be taken to rectify inequities due to Sec. 209(b) options? Should national eligibility standards be proposed?

BACKGROUND: Since its inception Medicaid has been a program of severe inequities, almost all of which have been mandated by law. A few examples of these inequities include the following:

In States without medically needy programs, individuals and families with even one dollar of countable income in excess of the cash assistance standards are ineligible for any Medicaid assistance; in States with medically needy programs, individuals with considerable excess income may "spend-down" to establish Medicaid eligibility.

The tremendous variation in the financial eligibility criteria from State to State means that families and individuals with identical incomes, ages and disabilities are eligible or ineligible depending solely on their State of residence.

The statutory discrimination against male-headed families, single individuals and childless couples means that such groups are generally ineligible no matter how low their income, unless they can establish eligibility on the basis of disability, blindness, incapacity or, (in some States, under certain conditions), unemployment.

Because only 17 States cover all children under 21 who are financially eligible, large numbers of needy children are being denied necessary medical care because they are in intact families.

In 14 States, which provide a spend-down option only through Sec. 209(b) of P.L. 92-603, aged, blind and disabled individuals in the same State can spend-down to establish eligibility, but AFDC-related individuals are denied Medicaid eligibility through the spend-down.

These are only a few of the program inequities which have been mandated by statute.

Some of the statutory inequities were introduced to establish national priorities for coverage (e.g. needy aged, disabled, or widows and orphans); the States have no control over these. There are numerous inequities which are created by the structure of the Medicaid program, which is to allow the States maximum flexibility to respond to their immediate budget conditions, by providing almost unlimited State options with respect to the groups covered, services provided and administrative methodology. While the principle of providing States with flexibility

is desirable, the results of the States exercising their various options had led to questions about the policy and to severe criticisms of Medicaid.

The open-ended Federal match, for example, was intended to provide incentives for States to design and implement liberal Medicaid programs, yet fewer than one-third of the States have utilized one of the most crucial options available -- that of providing coverage to all children under 21 who are financially eligible for medical assistance. The availability of unlimited Federal funds has not stimulated more than half of the States to set financial eligibility criteria at reasonably adequate levels nor to cover the medically needy or other optional groups. (In at least seventeen States, for example, less than one-third of the poor receive any Medicaid assistance.)* On the other hand, the availability of an unlimited Federal match has contributed to the establishment of very liberal Medicaid programs in the few States which have chosen to take advantage of the available Federal funds and whose tax base permitted extensive social service-related programs.

Virtually unlimited State options, combined with the absence of Congressional intent, have produced even more serious problems, relating to the extreme complexity of the Medicaid eligibility policy development process. The law and regulations are so complex that less than a handful of Federal employees are conversant with the issues and policies in effect. The administrative problems created by the absence of Federal policies in a large number of areas are vividly demonstrated by the fact that a large number of States are ignoring Federal requirements and proceeding independently. In brief, the present eligibility system is <u>unadministerable</u>.

The imbalanced results produced by the Medicaid law have been a source of concern for many who view the present day Medicaid program as a severe distortion of Congressional, Administration and State intent. Even more alarming is the sizeable expenditure of public funds for a program which provides only sporadic or no assistance to millions of individuals and families who need basic health care. A rethinking of the purpose of Medicaid along with necessary statutory changes are indicated.

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*Based on the ratio for 1970 of the number of Medicaid recipients in the State to the number of individuals in the poverty population in that State. Medicaid data from the National Center for Social Statistics; Poverty population data from the Census of Population.

OPTIONS:

Option 1: Terminate statutory discrimination against male-headed families, single individuals and childless couples (and other traditional "categorical" links) by establishing national Medicaid eligibility standards varying only by financial eligibility criteria, which will continue to be determined by each State. Mandate a medically needy "spend-down" program for each State. Mandate coverage of all cash assistance recipients for which the cash payment program meets Medicaid standards.

PRO: The basic justifications in the mid 1930's for limiting Medicaid assistance to the aged, blind, disabled and incapacitated are no longer as persuasive today when alternative categorical aid programs are available and when arguments for equity are compelling. In addition, there is public sentiment to reverse the unforeseen adverse effects of the AFDC program on family stability. The national health insurance debate in recent years has demonstrated an acceptance of the principle that sex, marital or parental status were not appropriate prerequesites to the right to health care and health care financing. Inclusion of the spend-down option (which utilizes the concept of maximum liability found in CHIP and other major NHI proposals), would assure that all individuals would have the benefit of medical assistance if their incurred medical costs were large enough. The requirement that all cash assistance recipients be automatically covered under Medicaid would remove the inequities (and the complexities inherent in the Sec. 209(b) option). Finally, preserving the State option of determining financial eligibility criteria would assure that such criteria reflect local standards of living.

CON: The primary disadvantage of this option is that it is only a half-way measure; State variation and inequities would still exist. Total reform of the Medicaid program requires establishment of nationally uniform financial eligibility criteria. The Medicaid experience has demonstrated that some States, if given virtually unlimited freedom in establishment of financial eligibility criteria, will not establish such criteria at a high enough level.

The second disadvantage of this option is that it would probably increase Medicaid costs considerably. While exact estimates are not available, the removal of the "categorical" requirements and the 209(b) option would probably increase Medicaid costs by about two billion dollars.

Option 2: Same as Option 1, but in addition, a national floor on the financial eligibility standards for Medicaid would be imposed. States would be free to continue establishing financial eligibility criteria at higher levels, but all criteria related to income (e.g., resources and income disregards) would be standardized. The States would be required to continue their FY 1975 financial efforts, with the Federal Government assuming the increased costs.

PRO: This option has the same advantages as cited above for Option 1. In addition, it has the advantages hoped for through the federalization of the adult categories under SSI, that of uniform national criteria at adequate minimal levels. It goes beyond SSI, to affect all population groups, not just the aged, blind and disabled.

CON: The increase in Federal costs could be considerable. Depending upon the nationwide financial eligibility level chosen, the increased costs could amount to five to eight billion dollars.

It would be inappropriate to undertake major reforms in Medicaid eligibility at this time, when NHI is imminent, and major efforts should be devoted to preparing and enacting it.

CONTRA CON: Arguments have been raised in response to the CON arguments above.

The increase in Federal costs would be more than outweighed by the programmatic advantages achieved by the changes. Furthermore, the experience of developing these proposals and of operating a Medicaid program with nationwide standards would be useful in the NHI debate.

Much of the increase in costs could be curtailed, by establishing, in addition to the nationwide minimum standards, nationwide maximum standards, for State eligibility. This move would not be inequitable, since all of the States would have spend-down programs.

The argument that such a major reform of Medicaid eligibility standards should not be attempted at this time because of the imminent enactment of a National Health Insurance law, may be countered by the considerations that:

(a) the implementation date of NHI will likely not be before 1979 or 1980;

(b) the reform of the Medicaid eligibility program cannot feasibly be tabled until such time because of the severe inequities and administrative problems which plague the program;

(c) the consideration of and enactment of legislation amending the Medicaid eligibility laws will require less consideration by Congress than a major NHI bill and therefore can be enacted fairly quickly. Submission of legislative proposals in mid-1975 will permit enactment by early 1976 and implementation by July 1, 1976.

(d) almost all major NHI bills have treated the low-income population separately for similar reasons: (1) they are generally unemployed or working at such low wages that health insurance from employers is infeasible; (2) their health care must be subsidized by either State or Federal funds, or both, because of their inability to pay for such care. Therefore, consideration of a national program of health care financing for the low-income population is not only feasible, but practical inasmuch as a comprehensive NHI system could be built on to a national program for the low-income population. Reform of the eligibility standards can be the first step in establishing such a program.

RECOMMENDATION: The options presented are acknowledged oversimplifications of possible legislative reforms of Medicaid eligibility. They have been presented to provoke interest in the question, and to weaken the rigidity which is implied in the refusal to consider major legislative changes in Medicaid.

It is recommended that the Department reconsider its position concerning Medicaid legislative proposals, and that it sponsor a discussion of legislative reforms of Medicaid eligibility. MSA will proceed to draft legislative options which embody Departmental objectives of simplifying Medicaid eligibility and of providing medical assistance to those <u>now</u> considered most in need of help.

D. EPSDT

ISSUE: What should be the Federal strategy in certain key areas of providing EPSDT health care to needy children?

BACKGROUND: EPSDT was created by the Social Security Amendments of 1967 effective July 1, 1969. Program regulations were issued by the Department in November of 1971. Eligible individuals under 21 were to be provided a screening "to ascertain their physical or mental defects," and such diagnosis and treatment as needed to correct or ameliorate defects. In addition to treatment and other services covered by the State's Medicaid plan, treatment for visual, hearing, and dental defects must be provided.

P.L. 92-603 added a penalty provision effective July 1, 1974, as an expression of Congressional dissatisfaction with the slow progress in implementing the program. This provision requires the Department to withhold one percent of a State's AFDC (title IV-A) funds if the EPSDT program is unsatisfactory. Seven States were penalized for the First Quarter 1975 and announced by the Secretary on June 2. (They are: Hawaii, Indiana, Minnesota, Montana, New Mexico, North Dakota, Pennsylvania.) Other States may be penalized for the same period.

Current Status of EPSDT

Through the end of Second Quarter FY 1975 (December 30, 1974), 2.2 million children (17 percent) had been screened out of an estimated 13 million eligible.

The general pattern of findings is as follows:

Percent referred (all conditions and ages) 47%

age	0-5	38%
	6-20	52%

Percent referred by condition (all ages)

for dental problems	25%
for vision problems	10%
for hearing problems	3%

Source: NCSS-120, part III

Current Activities

Over the past year, a large amount of time and attention has been given to the penalty provision of the EPSDT program. The Department has assessed the penalty where warranted, but at the same time has

promised to do far more than apply the fiscal sanctions. We have promised technical assistance, positive financial incentives, and other assistance to States to help them implement an effective EPSDT program. Such additional effort is needed if a quality, comprehensive EPSDT program is to be obtained.

There has been increasing concern about the quality of the EPSDT program as it currently exists, even (if not especially) in States which meet the minimal criteria for the penalty provision. A danger is that applying the penalty will become an end in itself and will not, as intended, function as a tool for achieving a better health program for needy children; the minimum (as defined by the penalty regulation) may become the standard of implementation.

If the Department overemphasizes the penalty provision (particularly since the penalty actions can be delayed in legal review), the Department will be vulnerable to criticism in the press, in Congress, and among the various lobby groups defending child health. Primarily, however, the penalty regulations are such that States may avoid sanctions and still fail to develop adequate EPSDT programs.

Title XIX already finances most of the health care for 13 million eligible children. Most of this care is still crisis-oriented, high cost care, and much can be done to reduce significantly the costs of medical care by shifting utilization patterns; the EPSDT program has many of the elements needed to do this:

...Screening, the "new" title XIX preventive health service, intended to detect diseases and defects at a stage when their correction would be least costly in dollars, health care resources, and human problems.

...Diagnosis and treatment of defects and diseases detected through the screening.

...The statutory responsibility to provide screening, diagnosis and treatment, and therefore the managerial requirement to link them. This case management assures a coherent approach to solving health problems, rather than the fragmentation which is currently characteristic of the health delivery system. Case management also provides a way of gaining more effective control of utilization of resources, including health supportive social services.

Briefly, the Federal strategy for providing health care for needy children should build on the existing EPSDT program by providing to States major management experience in organizing and delivering health services, while keeping costs under reasonable control, and by reaching the goal of improving the health care and health care experiences of 13 million needy children.

Outline of Strategy

To carry out this strategy, we are developing a number of specific steps:

1. EPSDT must bring together all of the now scattered functions: outreach, screening, referral, diagnosis, treatment, tracking, and periodic rescreening, into full case management. The SRS strategy for this aspect is described below.

2. Measures must be taken to overcome the reluctance on the part of many States to commit themselves fully to EPSDT because of their fears of financial over-runs and other perceived problems including:

   a. The lack of readily available dental services, and the huge amount of unmet needs for the costly services of dental screening and treatment, have made a number of States hesitant about implementing comprehensive programs which include dental components. (In some States, only EPSDT eligible children receive any title XIX dental services.)

   b. The turnover in the Medicaid rolls and the lack of continuity in eligibility means that some States are reluctant to initiate treatment programs if the patient is likely to lose eligibility during the course of treatment. Some treatment, particularly dental care, may require care extending for months beyond screening and the period of eligibility.

3. Action to improve the penalty provision itself, possibly by application of penalties to State administrative funds rather than to program funds.

SRS Strategy

SRS itself will provide most of the elements of the strategy. Despite delays, we are optimistic that staffing for EPSDT allocated by Medical Services Administration will be complete by about August 1. Our OPS objective will support many strategy elements, including further development of health and education activities to support EPSDT. New and improved regulations will strengthen both our ability to assess the penalty and the basic program.

Far too little is known about the impact of the program on children at present. Reporting requirements have been extensively revised to include diagnosis and treatment information, and a new requirement that States report cost data; cost-effectiveness, utilization pattern, and other analyses of the program and its variations from State to State will be made possible by these new requirements. A contract to develop better data for cost-effectiveness analyses and identify best practices has been signed.

Other major contractual support will aid program implementation during this fiscal year. In addition to demonstration and evaluation efforts continued from the past year, we have the following new support:

...intensive inter-disciplinary technical assistance to States with special needs.

...technical assistance to increase participation by providers.

...development of a management information system for EPSDT compatible with the Medicaid Management Information System (MMIS).

...formulation of ways for voluntary agencies and groups to assist the EPSDT program.

The cooperation of other parts of the Department are very important. We are working with the Office of Human Development to follow-up on the current EPSDT-Head Start collaboration. A role for the Office of Education, especially the Bureau of Education for the Handicapped, is being worked out jointly with OE. Highly relevant, too, is the role of the Public Health Service agencies. Working agreements have been developed with the National Institute of Mental Health, and other ways for PHS to assist are being sought. The role of these agencies will be coordinated by the Commissioner, Medical Services Administration.

ISSUES FOR SECRETARIAL DECISION: Several critical elements of the strategy are issues which require Secretarial support and decision. These issues are:

ISSUE 1: Should Federal financial participation be increased for dental services?

DISCUSSION: For many States, dental services are provided only for the EPSDT population. Dental services are typically not included in health insurance programs. Yet, in EPSDT, a minimum of 25 percent of all screened children have been found to have serious dental problems, and at least one State has decided to send children directly for dental work since their experience indicated over 90 percent with dental problems. It seems clear that the dental problem is of great magnitude, especially for the needy children served by this program. States fear the potential costs sufficiently that it blocks full implementation and commitment to EPSDT.

PRO: (1) States which have weak dental components would improve their services to children.

(2) More children would receive dental services.

(3) States which hesitate to commit themselves to EPSDT generally because of potential dental costs will be less hesitant.

(4) The Department would offer a positive incentive to States as opposed to the negative posture associated with the penalty.

(5) The precedent for a 90 percent match rate has been established in family planning.

CON: (1) Costs to Federal government would increase. Estimated annual increase for title XIX would be $100 million (Federal share).*

(2) Dental care is already required, and SRS should just enforce the requirement.

RECOMMENDATION: That SRS develop legislation necessary to increase FFP for dental care to 90 percent for a period of three years or until the backlog of unmet need in States is reduced.

ISSUE 2: Should eligibility be extended for individuals under treatment programs which begin as a result of EPSDT?

DISCUSSION: The major issue here is continuity of essential care despite lapsed eligibility for EPSDT. This is important for two reasons. The obvious consideration that incomplete treatment is at best no treatment at all; in many cases it is worse. Treatment providers (private physicians and dentists especially) are understandably wary of beginning a treatment program for which there may finally be no reimbursement. The result is an unwillingness to participate in EPSDT (or Medicaid) or fragmented care. In the EPSDT program there is an obligation to provide treatment; if screening uncovers a condition requiring extended treatment, then there appears to be a corresponding obligation to provide it.

PRO: (1) Recipients, providers, and States can be assured that reasonable treatment programs will not be interrupted and will be paid for.

(2) Providers who question the artificiality of eligibility criteria for the continuum of needed medical care will be more likely to participate.

(3) The goal of quality and comprehensiveness in EPSDT will be supported by filling a gap in our ability to assure treatment for conditions.

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*It is assumed here that utilization of dental services would double if the FFP rate were increased, from an estimated $80 million per year total to about $160 million. The Federal share would increase from $45 to $144 million. The $100 million increase is approximately equal to the amount which would be saved if FFP for adult dental care were withdrawn.

CON: (1) Some marginal new costs would be incurred, but are difficult to project.

(2) States should cover such cases themselves out of State revenues.

(3) An accountable mechanism for identifying pathological conditions uncovered for the first time as a result of the screening process would be difficult to create.

RECOMMENDATION: That the Department seek legislation to extend eligibility where necessary for four months of treatment, including financial incentives (increased FFP) if required to induce States to assure such treatment.

ISSUE 3: Should a new higher penalty approach be developed in which only administrative funds are affected?

DISCUSSION: A central weakness in the current penalty provision is its negative impact on the same population the EPSDT program is designed to help. In the June 2 press conference announcing the penalty, this question was raised repeatedly and we could not, in fact, be certain that AFDC benefits will not be adjusted by States to absorb the penalty. (See the issue paper on "Medicaid Regulations, Compliance, and Sanctions" for a fuller discussion of this issue.)

PRO: (1) The penalty would be selective and penalize directly the State, not recipients, thus avoiding potential limitation of services.

(2) The Federal government would get out of the anomolous situation of penalizing recipients for an administrator's failures.

CON: (1) The statute now calls for a 1 percent penalty. To be effective, the percentage would have to be raised to at least 10 percent to achieve a respectable dollar penalty. This would require legislative action.

(2) States can juggle accounts no matter how the penalty is taken; the net result of the change would not justify the effort to make it.

RECOMMENDATION: That SRS develop a proposal for legislative changes to assess the penalty against administration funds only, but increase the percentage to maintain the dollar level of the penalty.

E. Long Term Care

Organizational Arrangements for Long Term Care

Medical Versus Domiciliary Care

Personal Needs Allowances

ISSUE: Is the Department appropriately organized to carry out the Federal Medicaid policies regarding long term care?

BACKGROUND: At least forty percent of Medicaid's fifteen billion dollar expenditures this year will be devoted to long term care of the aged and the chronically ill. These services include those in skilled nursing facilities, intermediate care facilities, and some portion of the services in general and mental hospitals.

Earlier Experience

There has been considerable concern that the existence of Medicaid funding for these long term medical care institutions had, in fact, generated demand for these services. Many of the patients in these nursing homes were there in the absence of reimbursement or other arrangements for alternative settings and modes of care for the aged or infirm. Furthermore, the health and safety in these homes were not necessarily fulfilling even State standards for care and safety.

The inevitable conflicts and Medicaid trade-offs were most apparent in the nursing home program. The States established the reimbursement rates for these institutions, compatible with the kinds of licensure standards they wished to maintain, the pressures from providers and public groups and their own fiscal constraints. At the same time, State survey agencies certified providers to participate in the Medicaid program and determined whether these homes met the standards for participation. Homes which were found to be deficient could be excluded from the program, or they could be required to correct their deficiencies in order to continue in the program. The stricter the standards, the greater the deficiencies uncovered by the State survey agencies, the more corrective actions which had to take place, the more likely there would be pressure for increases in nursing home rates of reimbursements and the greater would be the costs of nursing home care. The States were torn by their desire to provide care for their needy aged and infirm, their need to provide this care under reasonable conditions, their accountability for huge sums of money, their responsibility to control Medicaid costs, their need to respond to pressure from politically powerful nursing home providers and their responsibility to certify these institutions for State and Federal standards.

The Federal government, at the early years of the program, relied almost exclusively on the State survey agencies to monitor the standards in nursing homes. In 1971, before President Nixon launched a large campaign to improve conditions in these nursing homes ("Federal moneys will not be used to reimburse substandard homes"..."Nursing homes should not be warehouses for the dying"), less than ten manyears in the ten SRS Regional Offices were assigned to reviewing the State systems for surveying and

certifying over 7,000 Medicaid homes and to implementing the Federal Medicaid long term care policies.

Conditions were sufficiently questionable for the Administration and Congress to agree on dramatic action. At least 150 new positions were created to implement the new efforts in long term care enforcement and improvement (110 of them in the SRS Regional Offices); an Office of Nursing Home Affairs was created in the Office of the Assistant Secretary for Health to coordinate Departmental policies in LTC; and deadlines were established for States to operate systems of certifying homes, detecting deficiencies and insisting on plans of correction as conditions for provider agreements.

The Social Security Amendments of 1972 established new, and generally more stringent policies in the area of long term care, particularly with regard to disclosure of survey information, utilization review, medical review, reimbursement, and the common standards and procedures, policies and conditions for certification of Medicare and Medicaid institutions.

Current situation

In the Central Office, Long Term Care staff are located in the Office of Nursing Home Affairs in ASH, a Special Assistant for Long Term Care in the Office of the Secretary, staffs in SSA/BHI, SRS/MSA and HSA/BQA. The Regional Office staffs are generally concentrated in each of the Regional Offices of Long Term Care Standards Enforcement (OLTCSE), located in the Offices of the various Regional Directors.

The organization of the Medicare nursing home enforcement program did not change substantially with the establishment of ONHA. Except for the fact that the enforcement units are located outside of SSA, and consequently have more limited program access, there are very great similarities between the current Medicare organizational arrangements and its earlier nursing home enforcement structure. The Federal Government has a direct and controlling relationship with the contracting survey agency. The OLTCSE has certification authority to direct, control and administer standards application, provider correction of deficiencies, provider termination and the survey process for Medicare homes. The Public Health Service, through the OLTCSE/Survey Agency relationship has a direct channel to influence consultation and provider improvement under Medicare.

None of these fortunate conditions pertain to the Medicaid Long Term efforts.

(1) The relationships under Medicaid are not Federal/provider; but Federal/State and State/provider. If fiscal sanctions are to

be applied under Medicaid, they must be applied by the Federal government on the State, not as in Medicare, on the offending nursing home. As has been emphasized in the issue paper on Compliance, Regulations, and Sanctions, the penalties which the Federal government can bring to bear on State governments are extremely limited. The influence of the OLTCSE units in the Regional Offices with regard to Medicaid nursing home enforcement is, therefore, similarly limited.

Success in obtaining corrective State actions is probably dependent upon the strength of the relationships with the State Medicaid agency. All legal and fiscal relationships are between the SRS Regional Commissioner and the State title XIX agency. The OLTCSE has no formal relationship with the Medicaid agency; it relates principally to the State survey agency. The OLTCSE does not relate programmatically with the SRS Regional Offices

(2) If a State is going to be held in non-compliance, then the long term care services cannot be isolated from the others of the 16 services and care available for Federal matching under Medicaid. The offenses and deficiencies have to be viewed in the context of the full gamut of services and requirements. The OLTCSE cannot be cognizant of all of the Medicaid programs; the MS staffs in the Regions, without special allocation of personnel, cannot be fully involved in the long term care enforcement effort. A comprehensive evaluation of a State Medicaid program is difficult to achieve within this arrangement.

(3) The OLTCSE efforts are focused on the survey and certification of Medicaid and Medicare providers. This is only a small aspect of the total Federal and State requirements controlling Federal matching under the long term care portion of Medicaid. In addition, SRS is responsible for assuring State compliance with requirements regarding utilization review, independent professional review, reimbursement, freedom of choice, State wide-ness, disclosure of survey information, licensure of nursing home administrators, among many other. The remaining SRS/LTC staff is too limited in size to address these basic long term questions.

(4) The Department's policies and procedures for LTC survey and certification have been promulgated in the Regional Director's Long Term Manual and various ONHA policy issuances to the Regional OLTCSE. There is real question whether these policies are defensible in court until the Manual and policy statements are incorporated into the SRS-State plan regulatory system.

(5) The fragmentation of the Medicaid program units has the inevitable deleterious effects of reducing communication between the different program segments, confusing and irritating the State agencies with multiple, overlapping visits and investigations, and with the absence of a single and well informed agent with

which the States could relate. The MSA Commissioner is still accountable to the Secretary and to the Congress for the Medicaid program; he has somewhat less than adequate influence over forty percent of that program in long term care institutions.

(6) The Office of Nursing Home Affairs was established to coordinate the policies which were common to Medicare and Medicaid in nursing homes. It should be emphasized that in the area of nursing homes, the two programs are more different than they are similar. Medicare limits its nursing home benefits to acute post-hospital care in skilled nursing facilities. Medicaid covers skilled nursing homes as well as intermediate care facilities, about 12,000 institutions. Medicaid benefits are more frequently long term benefits.

Medicaid patients in nursing homes tend to have exhausted all other possibilities of medical care and living arrangements. They tend to be the poorest and the sickest patients. Their medical, rehabilitative and social needs tend, on the average, to be quite different from those of Medicare patients.

OPTIONS: The huge amounts of money which are being spent in nursing homes, the tremendous role these nursing homes play and will play in the medical and social structure of this country, the political importance of the individuals and families involved in nursing homes and their patients all mean that the Department will have to concentrate priority attention on nursing homes and long term care over the next few years. With regard to improving the enforcement of nursing home standards, the Department has at least three options.

It could retain the present organizational arrangements. This has all of the virtues of the status quo -- its limitations and the advantages are known.

Secondly, it could enlarge the functions of the Office of Nursing Affairs to include responsibility for all of the long term care programs in the Department. The new organization would then be held accountable for all of the LTC aspects of Medicaid and Medicare as well as nursing home programs. Medicaid and Medicare program bureaus would be responsible and concerned only with the acute care programs outside of nursing home institutions. The fragmentation and the resulting confusion which characterizes the current situation would be reduced if not eliminated. UR, MR, IPR, reimbursement and all of the nursing home and long term care questions would be integrated. The six to ten billion dollar programs warrant their own organizational structure. The arrangement would presage the kinds of arrangements which would probably be appropriate to national health insurance (which tends to cover only acute care benefits).

On the other hand, it is questionable whether Congress would countenance such a major organizational change or would permit delegations of major segments of Title XIX. Long term care programs are considered part of the continuum of health care. Their complete separation from acute care may be arbitrary and unproductive. This second option would not resolve the anomaly of trying to administer a portion of the Medicaid program outside of SRS and outside of the relationships between SRS and the State Medicaid agencies.

The Department has a third option -- that would be to strengthen the program bureaus in the area of nursing homes and long term care, and return the Office of Nursing Home Affairs to the role of coordinating arm of the Office of the Secretary. ONHA would keep the Department informed of the immense activities across the spectrum of the agencies, and would assure the adoption of unified policies where these were appropriate.

RECOMMENDATION: The Office of Nursing Home Affairs and the Regional Offices of Long Term Care Standards Enforcement serve valuable functions in coordinating the Medicare/Medicaid efforts with regard to survey and certification of certain skilled nursing homes. On the other hand, the coordinating function has been exaggerated out of proportion and has served to subvent the more significant functions of integrating long term care programs into a more effective Medicaid program. Medicaid has become fragmented, with the Commissioner of MSA impeded from discharging his responsibilities of accountability for all of the Federal Medicaid program efforts.

Accordingly, it is recommended that the ONHA and the OLTCSE be retained for their coordinating functions and for providing assistance to the program bureaus responsible for their programs. Staffs, particularly in the Regional Offices would be redistributed to the program bureaus to function within those program units.

The less fragmented and the more self-contained the Medical Services Administration becomes, the more likely it will be to demonstrate the effectiveness of a Federal/State partnership in medical assistance to the needy.

ISSUE: How should title XIX institutions be defined to distinguish them from domiciliary care facilities?

BACKGROUND: Prior to PL 92-603, States could purchase medical care for welfare recipients either through Medicaid vendor payments to providers or by including the cost of the medical services in calculating the cash welfare payment to the recipient. As the Department stepped up its enforcement of the standards which Medicaid institutions must meet, some substandard skilled nursing facilities and intermediate care facilities were able to avoid meeting Medicaid standards of fire safety, sanitation and quality of care. They withdrew from the Medicaid program and received continued support of the patients in the homes, through the addition of the costs of their care to the patients' monthly welfare payments.

This practice resulted in Federal financial participation to medical institutions which did not meet Medicaid standards and it eroded the incentive for institutions to correct their deficiences in order to become certified for title XIX participation. To correct this failing, Section 249D of the Social Security Amendments of 1972 established there there would be no Federal matching of any portion of a State's cash payment which was used to pay for institutional medical or remedial care which was, or could have been, provided under an approved State Medicaid plan in an institution certified for title XIX participation.

The federalization of the adult cash assistance program, which became effective January 1, 1974, meant that the restrictions about Federal matching of State funds would no longer be meaningful. Substandard homes might be reimbursed through the Federal SSI payment and State supplementary payments. Accordingly, Section 14 of Public Law 93-233 established Section 1616(e), which extends the intent of Section 249D. Federal SSI payments would be reduced by the amount of the State supplementary payments which was used to pay for such medical or remedial care.

Implementing these sections requires a definition of "institutional inpatient medical or remedial care which is or could be provided by and institution certified under title XIX". A distinction has to be made between institutional care which could be delivered in a title XIX facility if it were able to meet the standards and requirements of title XIX and institutional care which was essentially a congregate residential facility.

Public Law 92-223, when it established intermediate care facilities as an optional service under title XIX, defined such institutions as being "licensed under State law to provide, on a regular basis, health related care and services to individuals who do not require

the degree of care and treatment which a hospital or skilled nursing facility is designed to provide, but who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities". ICF services may also include "services in a public institution for the mentally retarded or persons with related conditions if the primary purpose of such institution is to provide health or rehabilitative services for mentally retarded individuals" 45 CFR 249.10 embodies this language into the regulation.

OPTIONS: For SSI purposes, there appear to be two options for determining whether or not a home is a title XIX type institution, and therefore whether or not SSI funds would be subject to withdrawal.

The first option would be to define any institution which provided services "beyond room and board" as a title XIX institution. Then, all individuals who received State supplementary payments to cover the costs of institutional care which was in excess of the costs of room and board would be subject to review, and their SSI payments might be reduced by the excess. This definition would have the advantage of being the easiest to administer, requiring the fewest judgment calls. It would appear to be consistent with the first definitions of institutional medical or remedial care which were provided by the SRS regulation 45 CFR233.145(c)(2)(ii), to implement 249D.

On the other hand, such a simplistic definition would be strongly opposed by the States (who opposed it, but were unheeded for the one month that the earlier regulation was in effect). There are many institutions which provide care above room, board and laundry which are not medical or remedial in nature. Examples are, child care facilities, residential homes for the aged who are in good health, who receive certain social or recreational services, and half-way houses for persons released from penal institutions.

The second option would be to revise and clarify 45 CFR 233 and to issue a Program Regulation Guide which would spell out in more complete detail the conditions which determined the title XIX type care. The advantages of this option would be in the fairer treatment this would provide, and in the fact that it would probably be more consistent with the intent of withdrawing of Federal funds. It was not intended to penalize domiciliary facilities, but rather to assure that substandard medical institutions not be reimbursed.

The second option would have the additional advantages that it would be responsive to State demands and would allay some of the hostility which the "beyond room, board and laundry" has created. It might even forestall the Rostenkowski Bill HR 7938 which jeopardizes 1616(e).

The disadvantages are that the PRG would be extremely difficult to prepare, the distinctions are difficult to make, and there would be serious difficulty in getting agreement, particularly from the States, on an acceptable definition. Furthermore, such a PRG would inherently be more difficult for SSA to administer.

RECOMMENDATION: That the APA regulation be revised and the Program Regulation Guide be prepared after adequate consultation by MSA with SSA, ONHA. and various States.

ISSUE: Should regulations be amended with regard to personal needs allowance funds for individuals residing in medical institutions which receive Medicaid payments for their care and treatment?

BACKGROUND: Currently there are more than one million individuals who reside in institutions -- general and mental hospitals, skilled nursing facilities and intermediate care facilities -- which receive Medicaid assistance for all or part of the costs of care and treatment of these individuals. All of these patients are assured of a certain amount of money each month for their own personal needs -- clothing, haircuts, books, etc. Some receive a personal needs allowance through the cash assistance programs; others, who pay for some of their own medical care, are able to hold on to a certain amount of their income for their own non-medical expenses.

If all of the institutionalized Medicaid recipients have at least the $25 per month which the SSI program provides, then these personal needs allowances would total at least $300 million per year.

> Statutes and Regulations--Section 1611(e)(1)(B) establishes that "where an eligible individual or his eligible spouse (if any) is, throughout any month, in a hospital, extended care facility, nursing home, or intermediate care facility receiving payments (with respect to such individual or spouse) under a State plan approved under title XIX, the benefit under this title for such individual for such month shall be payable --
>
> (i) at a rate not in excess of $300 per year ..."

The AFDC program does not have an explicit statement concerning the income support for individuals in Medicaid institutions; general statements on reasonable income standards for Medicaid eligibility apply. 45CFR248.3(b)(4) presents a coherent approach to the "personal needs allowances" of the various cash assistance programs by stating, that, with respect to both the categorically needy and medically needy, every State plan must provide that a lower income level for maintenance must be used for individuals not living in their own homes but receiving care in institutions which are covered under title XIX. This lower income level must be reasonable in amount for clothing and personal needs for such individuals. It must be at least $25 per month for aged, blind and disabled and other individuals, although States may establish different income standards for the others if there is a reasonable difference in their personal needs.

45 CFR 248.3 (b)(4) provides for higher income allowances when institutionalized patients are maintaining personal homes for their dependents or even for a temporary period for themselves while awaiting a planned discharge from the institution. 45 CFR 248.3 (b)(5) insists that income must be applied first for an individual's personal needs and only after that for the cost of medical or remedial care.

45 CFR 249.12(a)(1)(iii) specifies with respect to Intermediate Care Facilities that each facility must have a written account, available to residents and their families, maintained on a current basis for each resident with written receipts for all personal possessions and funds received by or deposited with the facility and for all disbursements made to or on behalf of the resident. With respect to Intermediate Care Facilities for the Mentally Retarded, 45 CFR 249.13 (a)(1)(iii) requires further that the facility must have a written statement of policies and procedures that protect the financial interests of residents, and when large sums accrue to the resident, must provide for counseling of the resident concerning their use, and for appropriate protection of such funds.

The patients' rights in skilled nursing facilities (under common Medicare/Medicaid conditions of participation) include the right to manage his own personal financial affairs, or at least to be given a quarterly accounting of financial transactions made on his behalf, should he have delegated (in writing) this responsibility to the facility for any period of time. (20 CFR 405.112 (k)(6)).

Abuses of the Personal Needs Allowances

HEW Audits, GAO surveys, surveys by SSA and SRS Regional Offices, letters from the public, newspaper articles and Congressional queries have revealed instances of abuses of personal needs allowances. GAO is currently examining personal needs allowances and their control in five States - California, Florida, Michigan, Missouri, and New York. Extensive investigation of personal needs accounts have not been completed so that it is not yet possible to determine whether these abuses are isolated examples, or whether the problems are widespread. Some of the problems which have been identified include:

1. Misconduct or laxity on the part of the nursing homes in the oversight or protection of personal needs allowances, where the resident elected to have the fund managed and disbursed by the nursing home. Patients were not advised of their funds or their rights to use these funds. No records or accounts were available in some instances.

Patients were told that their requested expenditures were frivolous, inappropriate to their age or condition, or just "not good for them", and they were not permitted to make such expenditures. Patients were charged for medical care services which had been included in the negotiated per diem rate charged by the facility. Patients were charged for improvements which accrued to the benefit of the facility (curtains, furniture, paint). Patients were charged exorbitant rates for personal services: laundry, nursing.

2. Services and goods for which the personal needs allowances were intended were not available to the confined or bed-ridden patient, e.g., no haircutting services, no magazines or books, no rented televisions, no clothing shopping facilities.

3. In instances where the patients were unaware of their allowance or were unable to spend them, personal needs funds accumulated; neither the States nor the institutions maintained acceptable management or accountability practices with regard to these funds. In some instances, the homes retained the interest from large accumulated reserves. In some instances, the homes turned over interest from accumulated funds for the use of certain patients who, the Administrator felt, were more deserving. In at least one instance, GAO found a home turning over accumulated funds to the undertaker.

4. In many instances where personal needs funds had accumulated, or were "probably not going to be used as such" the nursing home forwarded the checks to the State or county. The State or local government, in these and in other instances, applied these personal needs allowances (in some cases Federal funds intended for another purpose) to reduce the State Medicaid costs.

Difficulties in Finding Solutions to Personal Needs Problems

1. The personal needs problem has suffered from the same difficulties which plague all of the Medicaid eligibility questions -- in order to protect individual rights and preserve State options, the solutions involving regulations become complex and not easy to administer. Staff to implement them, who must be capable and experienced in eligibility and income disregards and allowances are limited at the State, local and Federal Regional and Central Office levels.

2. The introduction of the SSI program has added a new dimension of complexity. The $25 per month allowances have no State involvement, and particularly in States which have agreements that SSA will administer the eligibility determination, the States have little or no commitment to protect these funds.

3. There is no single locus of responsibility for the personal needs allowances of Medicaid institutionalized patients, and therefore, no single place on which to assign accountability. SSI provices the $25 or more per month for those with little or no income, who are aged, blind or disabled. SSI may administer State supplmentation of this amount, if a 1634 agreement has been made, or States may administer the supplement. State and Local AFDC agencies may administer the personal needs allowances of AFDC-related patients with little or no income. For those with income from other sources, e.g., Social Security, annuities, workman's compensation or other disability or insurance funds, there is almost no accountability for these funds that are "left over" after the patient has paid toward his medical or institutional care.

4. The point at which all of these forces coincide is the institution in which the patient is residing; the element of accountability for the patient's rights is the State survey agency. This organization, has had little time or staff to devote to questions of personal needs, where problems of physical safety and quality of medical care are of greater urgency.

5. Audit agencies and financial management staff have had little time and resources to devote to monitoring these personal needs allowances questions. While $300 million annually is a substantial amount, it is not very significant in the face of the eight billion dollars for expenditures in Medicaid institutions.

6. There are too few exemplary practices of systems for protecting personal needs allowances, on which to base regulations or technical assistance.

7. There is a relatively common and pershaps puritanical belief that institutionalized persons who are receiving such mammoth subsidies of eight billion dollars for the costs of their institutionalization should really not be taking or keeping other funds; their expenditures would be wasteful and unnecessary since all of their basic needs are provided.

8. One school of thought believes that the personal needs allowances are personal, each individual has the right and the obligation to have exclusive control over them. Personal needs allowances are not an appropriate area of governmental regulation.

RECOMMENDATION:

1. A Task Force, consisting of representatives of the various interested Federal agencies (SRS/MSA; SRS/APA; SSA/BHI; SSA/SSI; SSA/OASDE; H/ONHA; H/BQA), be convened to investigate the extent of the problem and, if necessary, to develop consistent policies with regard to personal needs allowances and their control. Their report should be submitted by August fifteenth.

2. If further SRS action is considered desirable, then the SRS regulations should be amended to assure that States, and not just nursing homes are held accountable. As a condition of Federal financial participation, State plans should specify that there exists a system for monitoring personal funds and possessions belonging or accruing to patients in SNFs and ICFs. Such a system would protect personal funds and possessions by identifying the types of controls over such funds; assuring an acceptable accounting system; requiring an annual audit of such funds; monitoring local jurisdictions control of such funds; assuring a method of notifying individuals monthly of their balance and of their right of withdrawal of amounts prior to reaching the maximum allowable resource level; and establishing a policy with respect to disposition of such funds.

The monitoring system in each State should assure that personal funds are not used to purchase items of care or services required to be provided by the facility; that the individual has the right to manage his personal financial affairs; and that all facilities fulfill their share of obligations for accountability for personal needs allowances.

3. In support of this regulation, SRS should make available to all of the States, information on exemplary systems to monitor personal needs allowances.

APPENDIX

Research Questions

- Cost Sharing
- Alternatives to Institutional Care
- Mental Health
- Mandating Minimum Reimbursement Rates
- Capitation Arrangements
  - Statewide
  - HMOs
- Rural Health
- Female Recipients of Medicaid
- Health Education

Background Papers

- Buy-In
- Cost Differentials between ICFs and SNFs
- Prospective Reimbursement of Hospitals

Research Questions

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- Health Education

ISSUE: What has been the Medicaid experience with cost sharing by Medicaid recipients? What implications does this experience have for national health insurance? What savings will be achieved next year through the imposition by States of cost sharing measures?

BACKGROUND: There are, in practice, at least five major measures which States have used, so that Medicaid recipients share in the costs of their medical care. Some of these measures are not immediately acknowledged as cost sharing devices, but they all should be considered in analyzing the implications of Medicaid cost sharing for the development of any replacement programs.

1. Probably the most significant cost sharing measure is that which requires the Medicaid recipient to pay the costs of any medical care which he receives, which is not included within the State Medicaid plan. This amount varies from State to State, and may include any of the optional services ---e.g., drugs, ICF care, dental care, physical therapy, physical examinations; or it might include portions of the basic services---e.g., beyond a certain number of days of inpatient hospital care, or a certain number of physician visits, or care in a better quality nursing home than is covered by the State's negotiated rate. Indications of the amount of medical care which is not covered by certain State plans is found in the unshaded portions of the attached chart on "Medicaid Services State-by-State," or the attached table which shows the State by State variation in the average amount of medical expenditures for an AFDC family.

There is very little information on the practices of Medicaid recipients outside of the State plan benefits. For example, do Medicaid eligibles refrain from using services which are not covered? Are the medical care practices of Medicaid recipients distorted if the State provides coverage for the more expensive institutional care services, but does not cover preventive services? As an example, are "physical examinations" provided hospitalized patients but not those in physician's offices? The answers to these and other questions about uncovered services are important to the development of NHI as well as in determining State Medicaid policies. In periods of tight budgets, which services should be eliminated from the State plan and transferred to the risk of the recipient?

2. Those who qualify for Medicaid through the medically needy program pay for the costs of their medical care until the amount of their personal medical expenses exceeds the difference between their income and the State medical assistance standard. The amount which is "spent-down" is another Medicaid unknown, as are the kinds of services for which these expenditures are made. This information gap is a part of the serious lack of information on the medical expenditures of the various low income populations.

3. Special cost sharing measures apply to residents of medical care institutions. Recipients of institutional care pay out of their own income (social security, retirement, annuities, etc.), for the cost of their nursing home care, or forego welfare assistance until their residual income is some minimal amount equal to a personal needs allowance. In some of the Southern States, for the first years of the program, families were also expected to make additional contributions to the costs of institutional care of their relatives. The amounts of cost sharing in institutional expenses are not know; Medicaid expenditures for SNFs and ICFs reflect only the expenditures from the State Medicaid agency to the medical providers. The total cost of the care, including the recipients' contributions, is significant in determining policy with regard to long term institutional care as well as the alternatives to this institutionalization.

4. The Social Security Amendments of 1972 required States to introduce an income related premium for the medically needy. This measure was part of the cost savings package recommended by OMB. There was much opposition by the States to the mandatory character of this permium. Some argued that they could not, or would not, collect the premium, so that the requirement to impose it was, in effect, a reduction in Federal matching for States with medically needy programs. Senator Curtis introduced an amendment which made the imposition of a premium an option of the States. (PL 93-368, August 7, 1974) Only one State, Montana, had introduced the premium even while it was mandatory, and that premium continues at one to five dollars per month per medically needy family, depending upon the gross income of the family. It should be noted that since a large proportion of the medically needy are institutionalized, this premium appeared to be applied in addition to the needy spend-down and the institutional spend-down described above.

5. Prior to the Social Security Amendments of 1972, States believed that they were effectively precluded from imposing deductibles and copayments on Medicaid recipients. The statute required that such deductibles and copayments be reasonable related to the income of the recipient. Cash assistance recipients, with no funds available for medical expenses, were therefore exempted from these cost sharing measures. The States found that copayments and deductibles which varied by the income of the medically needy were administratively too costly and too complex to warrant introduction. There was considerable sentiment that nominal copayments and deductibles would reduce the escalation in the costs of Medicaid, by making recipients "stop and consider" their need for services, and thus reduce overutilization or use of unnecessary services. In response to this pressure, the Department agreed to a State-wide demonstration project in California, which was intended to show that with respect to the low-income Medicaid population, nominal copayments and deductibles would not impede necessary utilization, while having salutary effects on unnecessary utilization of health care services; further, that such cost sharing was

administratively feasible, and that the program savings would warrant the administrative costs of imposing such cost sharing measures.

The results of the California experiment are unclear and certainly controversial. It was agreed that cost sharing inhibited the use of certain patient-initiated medical services. On the other hand, there was disagreement on the cost implications of this reduction in services, both in the short and the long run. Furthermore, there was some difficulty in isolating the effects of cost sharing, since other utilization control measures (e.g., prior authorization of hospital procedures, and provider visits beyond a certain number) were introduced simultaneously.

The evaluation prepared by the State of California, which was generally supportive of copyaments and deductibles has been challenged.* The independent evaluation sponsored by SRS was not completed before its funding was terminated. It may be of some interest that the State chose not to continue the experiemnt, nor to impose copayments and deductibles when conditions for such cost sharing were liberalized with the enactment of the Social Secuirty Amendments of 1972.

The pressure for cost control and utilization control was reflected in the amendments of 1972, which permitted States to impose nominal copayments and deductibles on any of the optional services used by the cash assistance recipients, and on any of the services used by the medically needy. Arkansas requires recipients to pay fifty cents per prescription; New Jersey is considering a similar scheme. North Carolina, which had an extensive copayment system before the establishment of its Medicaid plan, has introduced a schedule of $.50 per prescription, $2.00 per dental visit, $1.00 per clinic visit, and $2.00 per set of eyeglasses for all recipients, as well as $2.00 per hospital day and $1.00 per physician, outpatient, or chiropracter visit for the medically needy. No other States have indicated that they will avail themselves of the possibilities of imposing copayments and deductibles. At the last two annual conferences of the State Medicaid Directors, there was considerably less interest in copayments and deductibles, with statements made that other measures were more effective and more equitable in controlling utilization, and that they administrative costs of these cost sharing measures were too great to warrant their use.

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* The State evaluation of the California experiment in copayments is contained in an article by Earl W. Brian and Stephen F. Gibbens, "California's Medi-Cal Copayment Experiment", in a special supplement to Medical Care, December 1974, Vol. XII, No. 12. A different point of view is presented in Milton I. Roemer, M.D., Carl E. Hopkins, Ph.D., Lockwood Carr, B.S., and Foline Gartside, M.A., "Copayments for Ambulatory Care: Penny-Wise and Pound Foolish", Medical Care, June 1975, Vol. XIII, No.6.

OPTION: A number of policy decisions will have to be made which depend on an understanding of the implications of cost sharing for the low income population. These decisions include those to be made by States on which benefits to include in (or withdraw from) the subsidized Medicaid package; what level to set the Medical Assistance Standard for the medically needy; what budget to allocate to long term institutional care; whether to have a medically needy program; whether to introduce copayments and deductibles as a cost control measure.

The Federal Government, both legislative and executive branches, are proceeding to draft national health insurance; most of these proposals involve some cost sharing devices, generally income related copayments and deductibles. Yet, as presented above, there has been little experience with the impact of these cost sharing measures on the low income population. In default of such experience, plicy decisions have had to be based on the effects of cost sharing on other income groups. The relevance of these experiences to the needy population is questionable.

Greater understanding of cost sharing and its impact on the medical care of the low income population is needed.

RECOMMENDATION: Accordingly, it is recommended that the Department undertake analyses of certain characteristics of medical care uses of the Medicaid and other low income populations.

The usefulness of these findings require that the studies be mounted quickly. They should include:

(1) An analysis of the health care utilization patterns of the low income population, and how these are affected by the methods of financing this care.

(2) An analysis of the patterns of utilization of Medicaid recipients and how this is affected by the availability of Medicaid financing for particular services. Do Medicaid recipients use less of the services which are not covered, than would be considered appropriate to their needs? Do these practices have any impact on the long term costs of Medicaid?

(3) What services are included in the "spend-down" of the medically needy, and what services are covered by the Medicaid medically needy program?

(4) What proportion of their medical costs are borne by institutionalized Medicaid recipients? What are the true costs of institutionalization?

(5) What has been the impact of nominal premiums, copayments and deductibles on the utilization patterns of Medicaid recipients? What techniques are administratively feasible? What impact do such measures have on provider participation in Medicaid? What have been the cost impacts of the measures use in the past?

MEDICAID SERVICES STATE BY STATE,

DECEMBER 1, 1974 1/

* BASIC REQUIRED MEDICAID SERVICES: Every Medicaid program must cover at least these services for at least everyone receiving federally supported financial assistance: inpatient hospital care; outpatient hospital services; other laboratory and X-ray services; skilled nursing facility services and home health services for individuals 21 and older; early and periodic screening, diagnosis, and treatment for individuals under 21; family planning; and physician services. Federal financial participation is also available to States electing to expand their Medicaid programs by covering additional services and/or by including people eligible for medical but not for financial assistance. For the latter group States may offer the services required for financial assistance recipients or may substitute a combination of seven services

Services provided only under the Medicare buy-in or the screening and treatment program for individuals under 21 are not shown on this chart.

Definitions and limitations on eligibility and services vary from State to State. Details are available from local welfare offices and State Medicaid agencies.

● offered for people receiving federally supported financial assistance

\+ offered also for people in public assistance 2/ and SSI 3/ categories who are financially eligible for medical but not for financial assistance

FMAP 3/	BASIC* REQUIRED MEDICAID SERVICES SEE ABOVE		Additional services for which Federal financial participation is available to States under Medicaid. Clinic services	Prescribed drugs	Dental services	Prosthetic devices	Eyeglasses	Private duty nursing	Physical therapy and related services	Other diagnostic, screening, preventive and rehabilitative services	Emergency hospital services	Skilled nursing facility services for patients under 21	Optometrists' services	Podiatrists' services	Chiropractors' services	Care for patients 65 or older in institutions for mental diseases	Care for patients 65 or older in institutions for tuberculosis	Care for patients under 21 in psychiatric hospitals	Institutional services in intermediate care facilities	
76	●	Alabama		●		●	●				●	●	●				●	●	● 5/	AL
50	●	Alaska									●					●		●	● 5/	AK
62		Arizona																		AZ
76	●	Arkansas	●	●	●	●					●	●			●	●	●	●	● 5/	AR
50	+	California	+	+	+	+	+		+	+	+	+	+	+	+	+	+	+	+ 5/	CA
57	●	Colorado		●		●			●		●	●		●		●		●	● 5/	CO
50	+	Connecticut	+	+	+	+	+	+	+	+		+	+	+	+	+		+	+ 5/	CT
50	●	Delaware	●	●					●					●		●	●		●	DE
50	+	D.C.	+	+		+	+		+	+	+	+	+	+		+	+	+	+ 5/	DC
61	●	Florida		●	●	●	●				●		●			●	●		● 5/	FL
67	●	Georgia		●	●	●	●	●		●		●	●	●		●	●		● 5/	GA
50	+	Guam	+	+	+	+	+		+		+	+	+							GU
50	+	Hawaii	+	+	+	+	+		+	+	+	+	+						+	HI
70	●	Idaho	●	●							●	●	●	●	●				● 5/	ID
50	+	Illinois	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+		+ 5/	IL
57	●	Indiana	●	●	●	●	●	●	●	●	●	●	●	●	●				●	IN
60	●	Iowa		●	●	●	●		●		●	●	●	●	●				●	IA
55	+	Kansas	+	+	+	+	+	+	+		+	+	+	+	+	+	+	+	+ 5/	KS
72	+	Kentucky	+	+	+	+			+		+	+				+	+	+	+ 5/	KY
73	●	Louisiana	●	●		●				●	●	●				●	●	●	● 5/	LA
70	+	Maine	●	+	+	+	+	+	+	+	●	+	+	+	+	+		+	● 5/	ME
50	+	Maryland	+	+	+	+	+		+		+		+	+		+	+		+	MD
50	+	Massachusetts	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+		+	MA
50	+	Michigan	+	+	+	+	+		+	+	+	+		+	+	+	+	+	+ 5/	MI
57	+	Minnesota	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+ 5/	MN
81	●	Mississippi		●	●							●				●	●		●	MS
60	●	Missouri		●	●						●					●	●			MO
66	+	Montana	+	+	+	+	+	+	+		+	+	+	+		+	+	+	+ 5/	MT
58	+	Nebraska	+	+	+	+	+	+	+		+	+	+	+	+	+	+		+ 5/	NB
50	●	Nevada	●	●	●	●	●	●	●	●	●	●	●	●		●	●		●	NV
62	+	New Hampshire	+	+	+	+	+	+	+	+	+	+	+	+	+				●	NH
50	●	New Jersey	●	●	●	●	●		●	●	●	●	●	●	●	●	●	●	● 5/	NJ
72	●	New Mexico	●	●	●	●	●	●	●		●	●	●	●					● 5/	NM
50	+	New York	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+ 5/	NY
70	+	North Carolina	+	+	+		+			+		+	+	+	+	+	+	+	+ 5/	NC
70	+	North Dakota	+	+	+	+	+	+	+	+	+	+	+	+	+	+		+	+	ND
54	●	Ohio	●	●	●	●	●	●	●	●	●	●	●	●	●	●		●	● 5/	OH
68	+	Oklahoma			+									+		+		+	+ 5/	OK
59	●	Oregon	●	●	●	●	●	●		●	●	●	●	●	●	●	●	●	● 5/	OR
55	+	Pennsylvania	+	●	●	●	+				+	+	+	●	+	+		●	+ 5/	PA
50	+	Puerto Rico	+	+	+				+	+	+						+			PR
55	+	Rhode Island		+	+	+	+						+	+		+			● 5/	RI
		SC																		SC
70	●	South Dakota	●	●		●	●		●		●	●	●	●	●				●	SD
72	+	Tennessee	+	+	+	+					+					+	+		+ 5/	TN
64	●	Texas		●			●			●	●		●	●		●	●		● 5/	TX
70	+	Utah	+	+	+	+	+	+	+		+	+	+	+	+	+		+	+ 5/	UT
65	+	Vermont	+	+		+					+	+		+		+		+	+	VT
50	+	Virgin Islands	+	+	+	+	+													VI
62	+	Virginia	+	+		+	+		+		+	+	+	+		+	+		+ 5/	VA
53	+	Washington	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+		+ 5/	WA
74	+	West Virginia	+	+	+	+	+	+	+	+		+	+	+	+	+	+		+	WV
60	+	Wisconsin	+	+	+	●	●	+	+	●	+	+	●	+	●	+			+ 5/	WI
61	●	Wyoming							●			●							●	WY
● 22	●		13	21	14	17	13	6	11	9	19	17	14	15	10	15	13	10	24	
\+ 31	+		28	29	27	26	25	15	24	16	24	25	23	24	17	26	18	15	25	
53	Total		41	50	41	43	38	21	35	25	43	42	37	39	27	41	31	25	49	

Intermediate Care Facilities (ICF) - P.L. 92-223 transferred the ICF program to Medicaid Title XIX) as an optional service, effective 1-1-72. States may at their option include institutions for the mentally retarded, both public and private. See footnote five.

1/ Data from Regional Office reports of characteristics to State programs and State plan amendments.

2/ People qualifying as members of families with dependent children (usually families with at least one parent absent or incapacitated).

3/ People qualifying as aged, blind, or disabled under the Supplemental Security Income program.

4. FMAP - Federal Medicaid Assistance Percentage. Rate of Federal financial participation in a State's medical vendor payment expenditures on behalf of individuals and families eligible under Title XIX of the Social Security Act. Percentages, effective from July 1, 1973, through June 30, 1975, are rounded.

5/ Including ICF services in institutions for the mentally retarded.

UNITED STATES DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE — Social and Rehabilitation Service — Medical Services Administration

Division of Program Monitoring

ISRSI-75-24801*

Cost Sharing

Average Medicaid Payment for Recipients of AFDC Cash Assistance, CY 1974

	Families	Children	Adults		
Alabama	560	90	390		
Alaska					
Arizona	-	-	-		
Arkansas	440	80	270		
California	1,080	240	470		
Colorado *	-	-	-		
Connecticut	780	170	430		
Delaware	660	120	410		
Dist. of Col.	1,260	260	670		
Florida	470	90	300		
Georgia	720	120	530		
Guam	340	40	240		
Hawaii	810	170	410		
Idaho	900	140	620		
Illinois	1,380	280	620		
Indiana	830	180	490		
Iowa	890	210	430		
Kansas	990	180	750		
Kentucky	510	90	320		
Louisiana	450	80	270		
Maine	860	150	490		
Maryland	860	190	470		
Massachusetts	1,130	350	330		
Michigan	1,270	220	790		
Minnesota	1,070	220	720		
Mississippi	250	60	120		
Missouri	380	80	240		
Montana	920	190	630		
Nebraska	830	170	500		
Nevada	1,190	190	1,000		
New Hampshire	790	140	500		
New Jersey	1,090	270	420		
New Mexico	700	140	410		
New York	1,730	500	490		
North Carolina	530	80	450		
North Dakota	860	170	590		
Ohio	1,000	180	600		
Oklahoma	580	170	190		
Oregon	510	100	320		
Pennsylvania	760	140	370		
Puerto Rico	190	40	20		
Rhode Island	940	180	520		
South Carolina	560	80	410		
South Dakota	540	100	360		
Tennessee	440	90	280		
Texas	820	130	540		
Utah	760	180	490		
Vermont	1,060	200	550		
Virgin Islands	120	20	80		
Virginia	800	160	450		
Washington	780	180	400		
West Virginia	790	160	360		
Wisconsin	1,080	300	470		
Wyoming	480	90	350		
U.S.	950	210	460		

Source: NCSS A-2 and B-1 Reports
* No data reported

DHEW/SRS/NSA/DPPE
June 26, 1975

ISSUE: What measures should the Department undertake to improve the availability of alternatives to long term institutional care?

BACKGROUND: The Medicaid program devotes almost six billion dollars, or almost forty percent of its expenditures to the area of long term care. Almost all of this six billion is for institutional care. Over one million Medicaid recipients spent some time this year in a nursing home, mental, general or tuberculosis hospital as a long term care patient.

Many studies have pointed to the over- and unnecessary utilization of institutional services. While acknowledging that appropriate nursing home care fulfills a valuable function, the excessive use of nursing homes has been deplored as inappropriate to the needs of the patients, not conducive to their recovery, degrading, debilitating and perhaps, even more costly than caring for the patients at home.

The excessive utilization of institutional care has been atributed to the fact that Medicare and Medicaid reimbursement were available for institutional services, that alternatives to institutional care did not exist in sufficient quantity, and when they did, they were not susceptible to reimbursement through federally matched programs.

To the degree that the concerns are valid and institutional care is inappropriate for some of the patients, then it would appear that the Department has at least three strategies which it might undertake to achieve more appropriate long term care of Medicaid patients. One, it might encourage the availability of "home health services" under Medicaid, by changes in the Federal regulation. Two, it might develop research or demonstration projects on the use of other alternatives to institutionalization along with the feasibility and desirability of funding these programs on a sustaining basis. Three, it might develop a legislative proposal which would present an integrated approach to the problems of long term care of the aged and the chronically ill, to replace the current fragmented and non-controllable programs.

The three strategies are relatively independent, and subject to very different time schedules. Each should be discussed and evaluated for its own merits.

ISSUE 1: What changes should be made in the home health regulation to increase the availability of home health services for Medicaid recipients, where home care is appropriate, necessary and part of the patient's plan of care?

BACKGROUND:

Need for New Regulation

For some time it has been recognized that a new Medicaid home health service regulation was needed. The existing regulation has been

charged by members of the Department, the Congress, State officials, the home health care industry and the public as a major impediment to the development of home health care services for Medicaid recipients.

Despite the fact that States are required to furnish home health services under Medicaid, and despite the consensus that providing health services in the home is certainly the more humane, and perhaps even less expensive, alternative to institutionalization, home health care expenditures remain at less than one-half of one percent of the Medicaid budget. Fewer than two hundred thousand Medicaid recipients received any home health services last year, compared to the more than one million who received nursing home services.

Some of the problems of the current regulation are inadvertent and can be easily overcome by issuing a new regulation which, as GAO recommends, would clarify the definitions of who may and who must be entitled to services, and who may be reimbursed as providers under the program. For example, there is ambiguity concerning the minimal set of home health services which States must provide under the State plan. Some States have misinterpreted the definition to mean that they are required to provide only one of the specified home health services (nursing, home health aide, supplies and equipment), when all are required to be available. Similarly, some of the States have applied Medicare requirements, which are more restrictive by statute, to Medicaid home health conditions, e.g., hospitalization as a prerequisite to home health services.

Generally Acceptable Regulation Changes

1. The new regulation should clarify the services which are required and optional. States must make available (as determined necessary by the recipient's physician and included in the plan of care) nursing services, home health aide services, medical supplies, equipment and appliances suitable for use in the home. States may provide physical, occupational or speech therapy to home health care patients, even though not generally provided to all recipients under the State plan.

2. The new regulation should clarify which recipients are eligible. There has been some confusion as to which Medicaid eligibles were entitled to home health care, even when physicians prescribed it. Was it only those in need of "skilled" nursing care? Was it limited to those leaving institutions or about to be institutionalized? We had stated before in policy guidelines and memoranda that none of these were the case, but to assure clarity, it appears necessary to incorporate this into a new regulation. Accordingly, the new regulation should state that in every Medicaid State those eligible for home health services, if needed, must include all of the categorically needy over age 21; all of the categorically needy under age 21, if the State plan provides

skilled nursing services for that group; all of the medically needy to whom SNFs are available. States may, at their option, provide home health services for any other Medicaid eligibles. The State may not impose requirements of either pre- or post-institutionalization for home health services, where a physician determines that such care is appropriate.

3. The new regulation should clarify the certification procedures for agencies offering home health services. These would essentially be Medicare's procedures with proper adaptation for additional kinds of providers appropriate to Medicaid.

OUTSTANDING QUESTIONS: In addition to the questions discussed above, on which there has been reasonable consensus within the various elements of the Department, the Congressional Committee staffs, and the APWA, there remain two highly controversial questions.

A. Should proprietary (private, for-profit) agencies be permitted to participate as home health service providers under Medicaid, where State laws do not exist to license them?

The Medicare statute requires that private for-profit agencies must be licensed under State law to participate as home health providers. In the absence of State licensing laws, the agency may not provide services and be reimbursed under Medicare. Medicaid does not have such a statutory provision, but because the current Medicaid regulation used Medicare home health standards, the same restrictions have existed. Ten States have enacted home health agency licensing laws (of these ten, New York specifically, prohibits proprietaries; Wisconsin requires licensure only of proprietaries). Because of these restrictions, plus very rigid interpretations of them by intermediaries and because of the high probability of retroactive denials, there have not been very many proprietary home health service agencies under title XVIII. It has been suggested that as a means of enlarging the number of home health service agencies providing services under Medicaid, the new Medicaid regulation should eliminate the restriction that proprietary home health agencies must be licensed by the State in which they participate.

PRO: 1. Removing the restriction would expand the number of providers participating and being created. Thus, increasing the availability of these services would represent a major step toward decreasing the use of inappropriate institutional care.

2. There is no comparable requirement for other Medicaid services. In fact, the requirement for licensure of proprietaries may be just a meaningless formality, with States assuming no responsibility for standards and performance.

3. Removes the discrimination against a class of providers, based on their motive for existence. Proprietaries have more incentive than

voluntaries to be efficient. Extension of accessibility to profit-making agencies may improve the possibility of restraining costs of home health care services, both through their economic incentives to be efficient and through the competition engendered by the increased number of participants.

4. It would be unfair to ban all proprietary agencies (in States which do not license them) because of the alleged abuse by some. It is the responsibility of the Federal and State agencies to prescribe appropriate standards for all providers to meet, and to provide sufficient controls to see that they are met.

CON: 1. It is unnecessary to remove the requirement, that State licensing of proprietaries is a prerequisite to participation, as a means of increasing the availability of services. States currently have the option of licensing proprietaries where they believe that the additional services are needed or worth reimbursement. States should be able to retain their restrictive options.

2. The potential for abuses in overutilization, poor quality service, improper reimbursement, and others, is at least as great in the home health field as it is for skilled nursing and intermediate care facilities. It is not certain that the Federal Government could develop standards that would prevent such abuse.

3. It is not certain that the Federal Government or the States could monitor such standards. The costs of the complex enforcement program that would be needed might outweigh the benefits gained from allowing new providers to enter the field.

4. A recent SSA proposal to allow sub-contracts with proprietary agencies (provided that their personnel are under the supervision of the voluntary agency) provides expansion of services, while maintaining control of quality.

5. The decision to remove the restrictions on proprietaries may be irreversible, even if abuses appeared.

RECOMMENDATION: SRS recommends the removal of the restriction on the participation of proprietary agencies to States which have licensing laws; instead the Federal regulation should provide standards which would permit the participation of proprietaries as well as voluntary agencies, and be applied to both.

B. Should single-service agencies be eligible to provide home health services under Medicaid?

Current eligibility is restricted to those agencies primarily engaged in providing skilled nursing care, which also offer an auxiliary

service, such as physical therapy. In addition to home health agencies, hospitals and skilled nursing facilities can qualify. It has been proposed that allowances should be made to permit participation of agencies which provide only one of the required home health services.

PRO: The action is considered desirable in stimulating the availability of home health care services, particularly in rural areas and other localities where no multi-service agencies were located or were willing to accept Medicaid patients.

CON: Concern has been expressed that single-service agencies may fail to recognize a recipient's need for a variety of services or may fail to make arrangements, through subcontract or referrals, for providing them, thus resulting in fragmented care for the patient.

RECOMMENDATION: Single-service agencies should be permitted only when they offer nursing or home health aide services. Such agencies are most likely to recognize the patient's needs and to make the necessary arrangements for meeting them. The requirement for plan of care developed and reviewed periodically by the patient's physician should serve as a safeguard against fragmentation. Easing the multi-service requirement should contribute to overcoming the lack of services available to Medicaid patients, particularly for those recipients who need only nursing or home health aide services, who are in areas where comprehensive agencies do not exist or are unwilling to serve them.

ISSUE 2: Should the Department attempt to encourage the availability of other services alternative to institutional care?

BACKGROUND: A FY 1971 research grant identified over twenty conceptual models outlining a variety of settings that could meet the needs of long term care for the elderly, impaired and chronically ill. The services provided in these models are essentially those provided in SNFs or ICFs reimbursed under Medicaid. Their difference is that the services are provided in non-institutional settings which do not require the patient to remain twenty-four hours a day, thereby eliminating room and board expenses from the medical bill. Furthermore, the avoidance of full-time institutionalization appeared less traumatic and destructive to continuing family relationhips and independent functioning.

Since that study, in addition to the services of home health agencies, SRS has experimented with four general classes of alternatives to institutionalization on a full-time basis:

1. Day Treatment Centers. Some examples of experimental centers, in which patients are transported to places where they receive rehabilitative and medical services, meals and social programs include: On Lok, geriatric services in North Beach section of San Francisco; Mosholu-Montefiore, using the Montefiore Medical Center in the Bronx; St. Camillus skilled nursing facility in Syracuse, N. Y., offers occupational therapy, physical therapy, pulmonary care, diabetic care and arthritic care.

2. Day Hospitals. The day hospitals, such as Burke Day Hospital generally offer more sophisticated care than would usually be found in a day treatment center for patients who generally have more chronic medical problems than those who would be cared for in a day treatment center. They generally require an intensive maintenance program to keep them from being hospitalized for long periods of time.

3. Community Care Organizations - One example, the Wisconsin CCO is exploring the potential for cost savings over nursing home costs, of providing health and health related social services (such as meals on wheels) to patients in their own homes.

4. Comprehensive Community-Oriented LTC Model. A proposed experiment to take place in Rochester, Monroe County, New York State would attempt to integrate institutional and ambulatory services to make them available to patients as appropriate to their conditions.

Many of the experiments are in proposed or early developmental stages, so that it is somewhat too early to judge their advisability or their comparative costs. Some conclusions based on a priori judgments should be mentioned:

a. One of the main reasons for institutionalization is the need for homemaker services and other chore services which are not appropriately charged to the medical care dollar. Yet, almost the only way in which patients may obtain these services (where there is FFP) is in nursing homes and other medical facilities.

b. The costs of providing homemaker, nutrition, medical, rehabilitation, nursing or therapy services are usually less expensive in a congregate setting than in sets of individual homes or even in centers to which patients have to be transported daily. Accordingly, it is reasonable to expect that the costs of taking care of an individual patient in a nursing home may occasionally be less than the costs of taking care of her in a setting alternative to this institutionalization. The relative costs of the two modalities would depend upon the degree of debilitation of the patient, the amount of "free" care available to her from other members of her family, and the amount of care and attention she requires. Until there are further results from these experiments in alternatives to institutional care, and until there is greater information on the degree of disability of patients in institutions and patients at home, it will be impossible to estimate whether costs will increase or decrease, and to what extent.

c. Regardless of whether unit costs will change and in what direction as a result of the introduction of alternatives to institutionalization, it is reasonable to expect that there will be increased demand for these services, and therefore increased costs as a result of their introduction. While some patients may be deterred or delayed in receiving care in institutional settings, other patients who were at home and receiving no services will now receive care reimbursed under the program.

These a priori conclusions have not been presented to discourage the development of alternatives to institutionalization. On the contrary, such experimentation is essential for us to understand the extent of institutionalization, the probability and feasibility of alternatives, and the relative costs of these substitutions. They are also essential if we are going to be able to present patients with a more humane method of treatment, where care in a nursing home is not prescribed nor desired.

RECOMMENDATION: That the Department, through SRS (MSA, CSA); HD (AoA, RSA); HSA (BQA); HRA (BRD) and the ONHA continue to support research and demonstration projects in the areas of alternatives to institutionalization. The evaluation of these projects should include the relative costs of these modalities, including Federal, State, Local, philanthropic, patient and patient's family and the relative satisfactions expressed by each of these factors. In addition, the various statistical and analytic organizations should continue to pursue research on the conditions of patients who are elderly and chronically ill, and their needs (in health resources, social services and fiscal resources) for care and attention.

ISSUE 3: Should the Department propose a legislative amendment to consolidate within a single comprehensive system, the multiple HEW programs which provide financial support or medical, social, rehabilitation or personal services for the long term care of the needy?

BACKGROUND: An immediate impetus for the development of a long term care legislative proposal was the promise which the Administration made that such proposal would be forthcoming this past spring, or at least before the reconsideration of National Health Insurance. CHIP contained no provision for the coverage of long term care; it left to a "residual Medicaid program" for a temporary period, the coverage of skilled nursing facilities, intermediate care facilities and home health services. Almost all of the other national health insurance proposals ignored the question completely, or built on the deficiencies of the current programs, or suggested very costly substitutes.

The major factors pressuring for the development of a coherent approach to long term care have been the failures of existing programs to provide the scope and coverage needed for an integrated system of benefits, and the failures to control huge, rapidly rising and apparently uncontrollable costs of long term care. The major programs have focused on the institutional needs of the aged and the disabled. Programs which should logically complement these with alternative modes of care and assistance have been administered under separate authorities, financed on a more uncertain basis and delivered through mechanisms whose relationships with one another and with the provision of institutional care were accidental at best.

To prepare an improved long term care program, certain conditions should be recognized:

.....the services required by the needy aged and disabled population transcend medical care services and must also include social, rehabilitative and personal care services:

.....coverage of all these long term care services for the poor is not appropriate to a health insurance program (because of the services included and the population covered):

.....while recognizing the inevitability of institutionalization for some, the program should provide and finance the range of services designed to keep people out of institutions, and in facilitating their discharge from these institutional settings:

.....Medicare and Medicaid are not now true long term care programs for the poor:

.....Medicare benefits are intended for the acutely ill, rather than the chronically ill. The amount, duration and scope of benefits are limited, and are closely linked to hospitalization.

.....Medicaid does not constitute a long term care program for the needy:

.....Medicaid services are generally provided only when the health of the individual has deteriorated and requires medical care, and then generally in the form of institutional services;

.....Medicaid benefits are limited in the range of alternative non-institutional services. Omissions include nutritional programs, home maker services, and other social services. Most of those included are at State option, so that there is considerable geographic variation in their availability;

.....Because of its eligibility restrictions--the categorical relationship, the variations by State, etc.--Medicaid does not cover all of the needy;

.....To be an improvement over the current system, and to be politically acceptable, a new long term care program would have to

.....Control the increases in costs, for the Federal government, which in turn, means
.....retain the State participation;
.....closed-end Federal appropriation;
.....reduce the bias of existing programs for costly institutional care

RECOMMENDATION: It is proposed that a major Departmental effort be assigned to the development of a long term care proposal which should be submitted to Congress simultaneously or even prior to the submission of the Administration's NHI proposal.

The details of this proposal will require considerably further exploration within the Department. But, as a debating beginning, we suggest that the program should consolidate within a single comprehensive system, the multiple HEW programs which provide financial support or medical, social rehabilitation or personal services for the long term care of the needy. The proposal should be addressed to the programs for the poor who are aged, disabled, mentally ill and mentally retarded. Its objective should be to assist the target population to maintain the highest degree of independence compatible with their physical, mental and emotional capabilities.

The proposal should present a single integrated system, consolidating the authorities, standardizing and simplifying the administration and, above all, restraining the costs of the programs, compatible with its objectives. The consolidation of the Federal programs in the long term care area should establish a locus and means of accountability for the performance of the Federal role in this LTC area. It should work to achieve the same integration at the State level, with similar potentials for capability and accountability.

"Title XXII," the Long Term Care proposal would have the following characteristics:

1. Each State, to qualify for the Federally matched program, would have to develop a plan for a system of long term care benefits for the needy, aged, disabled, mentally ill and mentally retarded.

2. Federal uniform minimum package of benefits, and services; minimum eligibility criteria.

3. The benefit package would consist of a consolidation of various HEW programs now operating under separate authorities, and the funds would be derived from the elimination of these separate entities. Examples include:

   Medicaid: SNF;ICF;LTC in hospitals (including psychiatric care); chronic outpatient care; home health care; maintenance drugs; buy-in for Medicare for needy eligibles.

   Cash Assistance: Residential and personal care in homes for the aged and similar institutions provided through special needs allowances.

Community Services: Nutrition services, homemaker services, social service counselling.

Rehabilitation Services: Special training and rehabilitative care.

Other Services: Day care, night care, halfway houses, community mental health centers.

4. Federal standards, such as medical review, utilization review, and physical and service standards would be established and enforced for the services authorized under the program.

5. Each State plan would provide for the establishment of an administrative structure which would:

.....create new delivery mechanisms by establishing or fostering the creation of Regional or local service organizations capable of coordinating and administering a complex of services tailored to individual needs of eligible persons in their areas. These Personal Care Organizations (PCOs) are analogous to Health Maintenance Organizations (HMOs) and may be developed by HMOs, medical foundations or other community agencies.

.....Contract with Regional or local service organizations in each area for the purchase of a coordinated and integrated range of services designed to provide care and support according to individual needs necessary to avoiding, delaying or minimizing institutionalization. (State-PSRO contracts might serve as a model here.)

.....Apply standards of institutions, agencies and services, utilized by local service organizations, and monitor utilization and adequacy of services.

.....Reimburse local service agencies on a capitation or other basis designed to promote effective and economical administration of benefits.

6. Ceilings would be established, at the time of appropriation, on the total Federal expenditures to match State expenditures. This Federal ceiling would be allocated on a State-by-State basis. The formula for the allocation of Federal financial participation would be a direct function of the size of the needy target population and inversely related to the per capita income of the State. Incentives to the States to emphasize particular kinds of care, such as

non-institutional services, might be introduced through special Federal matching. (Title XX model is appropriate, with differential match for certain incentive programs, and minimum contents of the package for any matching whatsoever.)

7. Links would have to be extended (with the potential for closer statutory attachments) with non-HEW programs, providing complementary services (HUD rent supplements, Agriculture's nutrition programs, VA's medical care programs).

ISSUE: Should the Department undertake major initiatives under Medicaid in the area of mental health?

BACKGROUND: Annually the Medicaid program spends over $500 million for the care provided to Medicaid eligibles in the institutions which have been specifically designated as being exclusively for the mentally ill or the mentally retarded. In addition, there are substantial, but not tabulated, expenditures under Medicaid for the care of eligibles in institutions providing mental care in a more generally classified institution (e.g., general hospitals); for mental health care outside of institutions (e.g., paychiatrists, community mental health centers); and for other medical care of Medicaid eligibles who have been classified as disabled by reason of mental illness or mental retardation, or who are family dependents of such disabled. To attribute to Medicaid a total of one billion dollars for the medical care of the mentally ill and the mentally retarded would probably be a conservative statement.

Thus, Medicaid is one of the largest single purchasers of mental health care. Yet, the actions taken by MSA to provide leadership in establishing standards for mental institutions, for improving the conditions of care in these facilities, and for developing new and better modes of treatment -- have been most notable by their absence.

It has been charged that: incarceration in mental hospitals is penal servitude without a fair trial; that conditions in public institutions for the mentally ill or mentally retarded are deplorable; that a large proportion of those in these institutions did not belong there at the outset of their stay; and that many in these institutions are not receiving care appropriate to their needs. If even a small percentage of these allegations are valid, then there is real basis for concern. Recent court rulings have emphasized the public responsibility for protecting the rights of mental health patients to kinds of care appropriate to their needs and condition.

It is apparent, unfortunately, that without significant efforts, there is little likelihood that the situation will improve. States have not presented plans for improvement in their institutions, nor do they appear to be developing comprehensive plans for mental health coverage, thereby promoting the availability and accessability of alternatives to insitutionalization for Medicaid eligibles. The greatest promise in this area appears to lie in exogenous factors, such as the increased use of chemotherapy and of birth control measures to reduce the incidence of mental illness and mental retardation, or in the introduction of national health insurance, which may improve the financing of mental health care.

It is also apparent that there are a considerable number of options for improving the mental health care of Medicaid eligibles, which the Department should be considering, accepting

or rejecting. Two factors should be emphasized before these optional actions are enunciated. First, as in other health areas, actions taken within the context of the Medicaid mental health programs, will have implications which transcend the services provided for Medicaid eligibles. Secondly, mental health coverage occupies a special place under Medicaid. Understanding the limitations on extensions of mental health benefits under Medicaid provide a reasonable clue to the relative weaknesses and strengths of the pressure groups in this area, and of the relative difficulties which the Department would face in achieving improvements in the care and conditions of the mentally ill or the mentally retarded.

Medicaid Coverage of Mental Health Care

In drafting and amending Title XIX, considerable pressure was exerted, first of all, to assure that States were not required to provide medical assistance in mental institutions. Unlike some other kinds of medical services, almost all coverage in this area was intended to be at State option. States were free to decide not only how much mental care and to whom the care would be given, but whether to include any mental institutional care at all in their State Medicaid plans. (An indication of some of the options which States have chosen and the variation in the mental health coverage is included in Attachment A). Secondly, Federal financial participation was restricted to limited kinds of care and to limited groups of recipients. (Some of the limitations on coverage are described in Attachment B). This restriction differed sharply from the approach to other medical care, where FFP was generally available for any medical service the State considered appropriate to Medicaid eligibles.

The reasons for these Federal policy positions, stemmed generally from three closely related conditions. First, the mentally ill and the mentally retarded were considered to have social diseases (and stigma) rather than medical conditions. Their care was therefore not considered a Federal responsibility, and,in fact, the less said about them, the more likely they would be to disappear. Secondly, the care of the mentally ill and the mentally retarded was expensive, long term, and not likely to result in cure or correction. Lastly, for all these reasons and others, the care of the mentally ill or retarded had traditionally been considered a personal or at most a State responsibility. State and Local asylums were considered the ultimate dumping grounds, particularly for the poor.

The campaign to provide Federal financial participation in the cost of providing Medicaid care for the mentally ill and the mentally retarded, has been led almost exclusively by Senator

Russell Long* and his staff. He has received support in these activities from States, needing fiscal relief in meeting their commitments and from State and Local Associations for Mental Health and for the Mentally Retarded.

Because of the tremendous costs that were feared, every Administration since 1965 has generally resisted enlarging the Federal financial role and has sought to limit the kinds of eligibles who would be entitled to care to the strongest political groups (the aged and the mentally retarded) and to those whose treatment would most likely be therapeutic (namely, the under twenty-one years of age, under active treatment in psychiatric institutions).

It is reasonable to expect that the groups which opposed enlargement of the Federal role, or which opposed increases in the requirements for State expenditures, would oppose massive costly efforts by the Federal government to improve the conditions in mental health institutions. It is also reasonable to expect that the same forces which achieved the coverage which exists and which have obtained significant mental health benefit packages in all of the national health insurance proposals would join a campaign to improve conditions and coverage.

OPTIONS: Listed below are a number of options available to the Department to improve the mental health care of Medicaid eligibles. These options have been listed in the order of the difficulty of introducing such measures; with the first listed being the easiest to effectuate and probably, therefore, likely to influence the least the conditions of mental health care. In determining the Departmental strategy, it is not necessary to limit the number of options chosen; they are intended to be complementary.

1. Prepare a statistical analysis of the magnitude of expenditures and the number of recipients of mental health care under Medicaid. In addition to the numbers and characteristics of recipients and providers of institutional care and the expenditures for each, the study would examine the size of the ambulatory care provided for the mentally ill or the mentally retarded. An analysis of the State plans and characteristics of the mental health coverage would be included.

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*Senator Long is credited with the first attempt in 1960 to permit Federal matching of vendor payments under Old Age Assistance for public mental hospitals. This amendment failed to pass, but some Federal financial participation was permitted for the first time for aged persons with a psychiatric diagnosis in general hospitals.

2. Prepare an evaluation of the quality of mental health care provided under Medicaid in the various States. This evaluation could be prepared by a new organizational unit in MSA, by an independent SRS contractor, by the National Institute of Mental Health, by a national organization (such as National Academy of Sciences or the American Psychiatric Association), or by Regional or State Medical or Psychiatric Societies. (The minimal effort would involve the presentation of a series of case studies of the kinds of care being reimbursed under Medicaid in a few States.)

3. Develop a system of public relations, which would publicize the conditions under which Medicaid recipients are receiving care, and if appropriate, the opportunities for improving these conditons. In addition to newsstories, published reports and statements before relevant Congressional Committees, the Department could create a Task Force to explore the questions; a Departmental coordinator of mental health activities could be announced, and substantive conferences could be held.

4. Extensive measures could be undertaken to implement the statutory requirements for assuring the quality of care provided in mental hospitals for the over 65, psychiatric hospitals for the under 21, and in intermediate care facilities for the mentally retarded. The Long Amendments and the Bellmon Amendment to Title XIX are extremely complete and explicit in their requirements on the States and on these institutions. (Resources may be limited and available to enforce only portions of these requirements.) These include the enforcement of requirements for certification and the accreditation of each of the institutions, the conduct of utilization review, medical review and independent professional review, the medical review of the patient's need for care in a mental hospital, the written plan of care, the periodic inspection of the facilities and the care provided for adequacy and appropriateness, the periodic certification, review and evaluation by physicians of the need for care and the appropriateness of that care, and the "active" character of that treatment. The monitoring of these requirements may be accomplished by enlarging the duties of the Office of Nursing Home Affairs, the Bureau of Quality Assurance, the Division of Utilization Control or Program Monitoring in MSA, or it might be the responsibility of a newly constituted Mental Health Enforcement Component of MSA and the MS units in the Regional Offices.

5. Enforce the State Plan requirements, of a more general character, with regard to the availability and accessibility of mental health services, particularly alternatives to institutionalization. The statute is complete and explicit, insisting on provider agreements and arrangements with State authorities concerned with mental diseases; joint planning and development of alternate methods of care, arrangements for readmissions where necessary, and arrangements for accessibility to patients and

facilities, information, and reports. Further, States must show that they are making satisfactory progress toward developing and implementing a comprehensive mental health program, including provision for utilization of community mental health centers, nursing facilities and other alternatives to care in public institutions for mental diseases. Implementation of these provisions could be in the form of a publicized new examination of the State plans and their conformance with these requirements; it could go further to evaluate the success of State actions in meeting Congressional intent; or still further, in introducing compliance precedures or withholding of Federal financial participation for failure to achieve these objectives.

6. Many aspects of Medicaid mental health coverage require States to maintain their efforts in that area so that Federal moneys are not simply substituted for moneys which the States would have paid out in the absence of the Federal program. Steps could be taken to enforce these "maintenance of effort" requirements, through either the provision of technical assistance to the States on how they could fulfill these conditions most effectively and improve the conditions of their institutions, or these requirements might be enforced through the withholding of FFP.

7. Enforce the regulation which prohibits discrimination in the provision of medical services by diagnosis of disease, particularly with reference to the availability and accessibility of services to the mentally ill, the mentally retarded, the drug addicts and the alcoholics.. Some of this will involve overcoming the traditional reluctance of medical care providers to provide care to the victims of such diseases, particularly when the victims are poor. Much of this effort may be directed toward changing State plans which discriminate in the kinds of mental health care permitted (e.g., number of visits to psychiatrists, psychologists or psychiatric clinics), but the likelihood of enlarging State benefit packages in the mental health field is remote.

8. Evaluate the advantages of enlarging the minimum mental health coverage under Medicaid. In particular, study the desireability of extending coverage in mental hospitals to the 22 to 65 age bracket. If there are positive implications in the enlargement of such coverage, then propose a legislative amendment to title XIX.

9. Develop national health insurance proposals which would build on the experiences of the Medicaid program, and yield improvements in the care of the mentally ill and the mentally retarded and those who have been placed in institutions for the mentally ill or retarded.

RECOMMENDATION: The Department should establish Medicaid mental health programs as a priority target for the forthcoming year. In this regard, the Department should announce that it is exploring the problems of the mentally ill and the mentally retarded who are Medicaid eligibles. We will take corrective actions to the extent that these studies indicate that actions are warranted and resources may be made available.

Specifically, we recommend that Option 1, that of preparing a statistical analysis of Medicaid mental health expenditures, recipients and providers, should be undertaken immediately within the staff of MSA, with the advice of NIMH.

Option 2, the evaluation of the quality of mental health care, should be begun within the next few months. A suggested method of undertaking this study would be to seek the support of Senator Russell Long, and the advice and perhaps participation of the National Academy of Sciences, the American Psychiatric Association, or such prestigious group.

All of the options 3 through 9 are contingent upon the results of 1 and the preliminary results of 2. It is recommended that plans not be prepared until these results are in.

Attachment A

PSYCHIATRIC COVERAGE UNDER MEDICAID

	Psychiatric hospital services for those over 65	Psychiatric hospital services for those under 21	Psychiatric hospital services for those 21 and over	Psychiatric clinic services	Other practitioners' services	Prescribed drugs	Dental services	Eyeglasses
TOTALS								
Alabama	--	see attached	--	X	--	--	--	--
Alaska	--	X	--	X	--	--	--	--
Arizona								
Arkansas	X	X	X	X	--	X	--	--
California	X	X	X	X	--	X	see attached	see attached
Colorado	X	X	X	X	--	--	--	X
Connecticut	X	X	X	X	--	X	X	X
Delaware	X	--	--	X	--	X	--	--
Dist. of Col.	X	see attached	--	X	--	X	--	--
Florida	X	--	--	X	--	--	--	--
Georgia	X	--	X	X	X	--	--	--
Hawaii	--	--	X	--	see attached	X	--	--
Idaho	--	--	--	X	--	X	--	--
Illinois	X	--	X	X	--	X	--	--
Indiana	--	--	--	--	X	X	--	X
Iowa	--	--	--	--	--	--	--	--
Kansas	X	X	--	X	--	X	--	--
Kentucky	X	X	--	X	see attached	X	--	--
Louisiana	X	X	--	X	--	X	--	--
Maine	X	X	X	X	X	X	--	--
Maryland	X	--	--	X	--	X	--	--
Massachusetts	X	--	X	X	--	X	--	see attached
Michigan	see attached	see attached	--	X	--	X	--	--
Minnesota	X	X	X	X	--	X	--	--
Mississippi	X	--	--	--	--	--	--	--
Missouri	X	--	--	--	--	--	--	--
Montana	X	X	X	X	--	X	--	--
Nebraska	X	--	X	X	X	X	see attached	--
Nevada	X	--	--	--	--	--	--	X
New Hampshire	X	--	--	--	--	X	--	see attached
New Jersey	X	X	--	--	--	X	--	see attached
New Mexico	--	--	--	X	--	X	--	X
New York	X	X	X	X	--	X	--	--
North Carolina	X	X	--	X	--	X	--	--
North Dakota	X	X	--	--	--	X	--	--
Ohio	see attached	X	see attached	X	--	X	--	--
Oklahoma	X	X	--	X	--	--	--	--
Oregon	X	X	X	X	--	X	--	X
Pennsylvania	see attached	X	see attached	X	see attached	X	--	--
Rhode Island	X	--	--	X	--	--	--	--
South Carolina	X	X	--	X	see attached	--	--	--
South Dakota	--	--	--	--	--	X	--	--
Tennessee	X	X	X	X	--	X	--	--
Texas	X	X	--	X	--	--	--	--
Utah	X	X	--	X	--	X	X	--
Vermont	X	X	--	--	X	--	--	--
Virginia	X	--	--	X	--	X	--	--
Washington	X	--	X	X	--	X	--	X
West Virginia	X	--	X	X	--	X	--	--
Wisconsin	X	X	X	X	--	X	--	--
Wyoming	--	--	--	--	--	--	--	--
American Samoa								
Guam	--	--	--	--	--	X	--	--
Puerto Rico	--	--	--	--	--	X	--	--
Trust Territories								
Virgin Islands	--	--	--	--	--	--	--	--

X Provided, no limitations.
-- Not provided.

Psychiatric Coverage Under Medicaid

Alabama

Psychiatric Hospital Services for Persons Under 21 - 30 days per calendar year; additional days may be provided when written pre-authorized.

California

Psychiatrist - 5 psychiatric out-patient visits in 6-month period.

Psychologist - No limitations for categorically needy. For medically needy only within 90-day period following institutional care.

Connecticut

ICF for the Mentally Retarded - Level of care is determined within 14 days of the patient's admission to the facility and the need for continued care in the facility is periodically determined thereafter.

Psychologists - therapy services may be given only under the direction or consultation of a psychiatrist.

District of Columbia

Psychiatric Hospitals for those under 21 - Length of stay is limited to 30 days.

Georgia

Clinic services is limited to those services provided by out-patient mental health clinics.

Out-patient psychotherapy is limited to a maximum payment of $250 per patient per calendar year.

Hawaii

Out-patient psychiatric clinic services are initially authorized for 4 visits during a 12-month period. Additional visits of no more than 8 visits may be provided following the approval.

Kentucky

Out-patient psychiatric service procedures rendered by other than board-eligible and board-certified psychiatrists are limited to 4 such procedures per patient per physician per calendar year.

Maine

Psychological Examiners - Limited to psychometric testing.

Massachusetts

Psychologists - Only testing and evaluation service may be provided by psychologists.

Michigan

Psychiatric Hospital for those over 65 - Minimum period necessary for proper care and treatment. Prior authorization required after 12 days, 18 days and each 30 days thereafter.

Psychiatric Hospital for those under 21 - (Same as for over 65)

Nebraska

In-patient psychiatric hospitalization in other than Nebraska Regional Centers shall be confined to 14 days. An exception may be made where the attending psychiatrist requests such extension by the 10th day of hospitalization and fully documents the need for same, but under no circumstances will combined in-patient coverage be provided for a total of more than 30 days in any 12-month period for any one recipient.

Nevada

Psychologist - Prior authorization required after review and evaluation of medical need and social situation.

New Hampshire

Psychologists - Limited to maximum of $500 per fiscal year per patient.

New Jersey

Psychological Services are provided. Prior authorization by State office for services exceeding a cost of $300 in any 12-month period is required. Psychologists practicing in States other than New Jersey are not eligible for reimbursement.

New York

Psychiatric day care and night care services provided.

Psychological testing.

Ohio

Psychiatric Hospital for those over 65 - Provided as long as care is necessary. Skilled Nursing Facility for Mentally Ill - Provided in public institutions $11 per day for maximum care and $8 per day for average care.

Pennsylvania

Psychiatric Hospital for those over 65 - Unlimited care in public institutions, up to 60 days per benefit period for persons in private institutions.

Skilled Nursing Facility for Mentally Ill - 65 and over unlimited care in public institution. Up to 60 days per benefit period in private institutions.

Psychiatric Clinic - Limited to 120 days in consecutive 12 month period.

Rhode Island

Psychiatric hospitals limited to 150 days.

Vermont

Clinic - Limited to physician-directed mental health clinics.

Physicians' services for treatment of mental, psychoneurotic or personality disorders are limited to a maximum of $500 in a calendar year.

West Virginia

Psychologists - No limitations for medically needy or categorically needy. Prior authorization required for therapy.

Psychiatric Hospitals for those over 65 - Limited to 90 days per fiscal year.

ATTACHMENT B

Statutory (Title XIX)

Limitations on Medicaid Coverage of the Mentally Ill or the Mentally Retarded

Currently, Federal financial participation is permitted for the following services for the Medicaid eligibles who are mentally ill or mentally retarded:

(a) Required to be offered by every State Medicaid plan: inpatient general hospital services; outpatient hospital services; other laboratory and X-ray services; skilled nursing facility services (other than services in an institution for tuberculosis or mental diseases) for individuals 21 or older; EPSDT: family planning services; physician services; home health care services;

(b) At the option of any State: medical care, remedial care recognized under State law; private duty nursing services; clinic services; dental services; prescribed drugs, dentures, and prosthetic devices and eyeglasses; other diagnostic, screening, preventive and rehabilitative services; intermediate care facility services (other than in an institution for tuberculosis or mental diseases);

(c) Specifically with regard to institutions for mental diseases, at State option: inpatient hospital services, skilled nursing facility services, and intermediate care facility services for individuals 65 years of age or over in an institution for tuberculosis or mental diseases; inpatient psychiatric hospital services for individuals under age 21; intermediate care facility services for the mentally retarded.

With respect to all services provided under the Medicaid State plan, there are Federal restrictions to assure that the services paid for are necessary and appropriate to the medical needs of the patient.

Systems of utilization review, medical review and independent professional review are required, as well as periodic certification and review by a physician.

In addition to the general requirements, there are conditions specifically directed to the intention of limiting care in mental institutions. For example, if the State plan includes medical assistance in behalf of individuals 65 or older who are patients in institutions for mental diseases, then it must provide for having in effect, agreements or arrangements with State authorities concerned with mental disease and with institutions needed for carrying out the State plan. These should include arrangements for joint planning and for development of alternate methods of care, arrangements providing assurance of immediate readmittance to institutions where needed for individuals under alternative plans of care, and arrangements providing access to patients and facilities for furnishing information and for making reports. The State plan must also provide for an individual plan for each such patient to assure that the institutional care provided to him is in his best interest, including assurances that there will be initial and periodic review of his medical and other needs, that he will be given appropriate medical treatment within the institution, and that there will be a periodical determination of his need for continued treatment in the institution. There must be provision for the development of alternate plans of care, making maximum utilization of available resources, for recipients 65 or older who would otherwise need care in such institutions, including appropriate medical treatment and other aid or assistances, and for methods of administration necessary to assure that the responsibilities of the State agency under the State plan will be effectively carried out.

There must be methods for determining the reasonable cost of institutional care for such patients.

Furthermore, with regard to inpatient psychiatric hospital services for individuals under age 21, the hospitals must be accredited as such by the Joint Committee on Accreditation of Hospitals; the care of the patient must involve active treatment meeting Secretarial standards, the treatment must be necessary, expected to improve the condition so that further treatment will no longer be necessary. In addition, there must be reasonable assurance that the Federal funding will not be used to replace State funds, but rather to expand or improve conditions.

With regard to public intermediate care facilities for the mentally retarded, the statute requires that these institutions be primarily intended to provide health and rehabilitative services for the mentally retarded, that such services meet standards prescribed by the Secretary, and that the treatment be "active". Federal financial participation must be used to expand services in each institution, not to replace State expenditures. (States must, therefore, maintain effort.)

ISSUE: To encourage provider participation, (particularly physicians), should the Federal government require States to pay minimum rates? If so, what criteria should be used to evaluate these minimums? Would federally established minimum reimbursement rates require a legislative amendment?

BACKGROUND: There are significant instances in which health care providers have not participated in Medicaid. In New York City, for example, less than one-third of the physicians accept Medicaid patients. (Signs appear saying, "No Medicaid Patients"; "No Medicaid Prescriptions") While almost all California physicians accept some Medicaid patients, quite a few accept only a limited number of such patients. Among the reasons cited by non-participating physicians are that Medicaid rates of reimbursement are too low.

Many of the moderate quality skilled nursing homes state that they are unable to serve Medicaid patients at the low rates set by some States. Home health agencies have complained that the low State rates make it impossible for them to provide services for Medicaid patients except at a loss, to be made up by philanthropic contributions or higher rates to private patients.

States have frequently met fiscal crunches by cutting Medicaid expenditures, through cuts in daily rates and in fee schedules. Medicaid total expenditures have been reduced first, by the cuts in the unit costs of services actually delivered and, secondly, by cuts in the amounts of services being delivered as the number of providers who were willing or able to participate at lower fees was reduced.

Survey of Physician Reimbursement

Last year, MSA conducted a survey of the State methods of reimbursing physicians in April 1974. As noted in Table 1, States reimbursed physicians according to fixed fee schedules, relative value scales, or usual and customary charges (with different possible ceilings and with different possible base years).

Fewer than fourteen States paid for services at the current usual and customary charges (with a ceiling of the 75th percentile). In all of the other States, physicians were paid less than the Medicare rate and less than their on-going, usual and customary charges for rendering Medicaid services. Base periods for determining usual and customary were set as long ago as six or seven years. States set ceilings on "usual and customary charges"; they paid considerably less than the 75th percentile.

Impact of Low Reimbursement Rates

Arguments have been raised that the State low reimbursement rates have impeded participation in Medicaid. Furthermore, it has been charged that the low reimbursement rates, which helped to reduce provider participation, were, in many instances, counter productive,

Table 1: Physician Reimbursement Under Medicaid

	Usual and Customary, 75th Percentile Ceiling (Title XVIII)	Usual and Customary, With Ceiling Set by State	Percentile Ceiling is Set At	Base Period for Used Data	Fixed Fee Schedule	Relative Value Scale	Fee for Initial Office Visit, Routine	Fee for Routine Follow-up Office Visit	Physician Reimbursement Limited to 5% Above Medicare
TOTALS									
Alabama	X	-	-	-	-	-	$25-$35	$10-$15	No
Alaska	X	-	-	-	-	-	-	-	No
Arizona									
Arkansas	X	-	-	-	-	-	-	-	No
California		-	60	1965	-	X 1/	$11	$10.25	No
Colorado						Y			
Connecticut	X		-	1972			$ 9	$ 4.50	No
Delaware	X			Medicare			$7-$5;$10-$7	-	Yes
Dist. of Col.									
Florida	-	-	75	FY 1972	-	X 1/	$10	$ 8	Yes
Georgia	-	X	-	1968	-	-	$14	$10	No
Hawaii	-	-	63	1967	X	X 1/	$ 5	$ 5	No
Idaho	X	-	-	-	-	-	-	-	No
Illinois	-	X	70	CY 1971	-	-	$12	$ 8	No
Indiana	X	-	-	-	-	-	-	-	No CI
Iowa	X	-	-	-	-	-	-	-	No
Kansas		X	50	-	-	-	$ 8	$ 6	No
Kentucky		X	-	1967	-	-	$14	$ 5	No
Louisiana		-	-	-	-	X 1/	$ 6	$ 6	No
Maine	X	-	-	-	-	-	-	-	No
Maryland			60% of 75th	1/1/69	-	-	$ 6	$ 6	No
Massachusetts		X	50	1971	X	-	$15 or $10	[illegible]	Yes
Michigan		X	75	CY 1972	-	-	$25	$ 8	No
Minnesota	X	-	-	-	-	-	-	-	No
Mississippi	-	-	-	-	X	-	$ 8	$ 4	No
Missouri		X	-	-	-	-	$5 - GP $8 - Spec	-	No
Montana				[illegible]		[illegible]			
Nebraska	-	-	-	-	-	X 1/	$10	$ 5	No
Nevada	-	-	50	CY 1972	X	X 1/	$10.00	$ 5.00	Yes
New Hampshire	X	-	-	1972	-	-	$25	$15	No
New Jersey									No
New Mexico	X	-	-	-	-	-	-	-	No
New York	-	-	-	-	X	X	$ 7.00	$ 6	Yes
North Carolina		X	90% of 75th	6/73	-	-	$12.20/$5.00	$8.00/7.00	Yes
North Dakota		X		[illegible]					
Ohio		X	75	CY 1973	-	-	$25 or $10	$10	Yes
Oklahoma	X	-	-	-	-	-	-	-	No
Oregon		X	64.5	7/1/73	-	-	$ 5.50	$ 5.50	Yes
Pennsylvania									
Rhode Island	-	-	-	-	X	-	$10	up to $10	Yes
South Carolina	X	-	-	1970	-	-	-	-	No
South Dakota	\			[illegible]					
Tennessee	X	-	-	[illegible]	-	-	$10.50	[illegible]	Yes
Texas	X	-	-	-	-	-	-	-	No
Utah		\		[illegible]					
Vermont	X	-	75	CY 1[illegible]	-	-	$ 8	$10	No
Virginia		X	-	1[illegible]			[illegible]	[illegible]	No
Washington				[illegible]		X 1/	[illegible]	[illegible]	No
West Virginia		—				[illegible]	[illegible]	[illegible]	No
Wisconsin		-	-	-	-	-	-	-	No
Wyoming									
Guam									
Puerto Rico									No
Virgin Islands	\								

1/ States indicating both Relative Value Scale and Usual and Customary with State ceilings as basis for reimbursement.

Source: April 1974 Survey of States; HSIIS 74-57

yielding increases rather than decreases in costs. In these cases, Medicaid eligibles' reacted to the shortage of providers by delaying medical attention until more costly care was needed, or by substituting more expensive alternative forms of care that did happen to be available.

For example, the low rates for physicians in New York City and the refusal to accept Medicaid patients have meant that many Medicaid recipients have used services in hospital outpatient clinics and emergency rooms at costs that were four times the scheduled rate for Medicaid physician office visits, and at least three times the prevailing rate for physician visits. Similarly, the "over-utilization" of costly nursing home care has been attributed to the dearth of home health services, for which reimbursement was not available at market prices or at costs.

Statutory Maximum Payments

There are a number of instances in which the title XIX statute establishes maximum levels for Medicaid payments to providers. Section 1902(a)(30) requires that State plans provide methods to assure that payments are not in excess of reasonable charges consistent with efficiency, economy and quality of care. Section 1902(a)(13)(D) provides that the reasonable cost of inpatient hospital services shall not exceed the equivalent Medicare determinations. According to section 1903(i), physician fees may not be greater than that paid at the lowest 75th percentile of prevailing charges in the area. Section 1903(h) requires that there be a reasonable differential between the average payments for ICFs and for SNFs. Section 1903(i) essentially limits payments for selected items or services to the lowest charge levels at which social services are widely available.

Statutory Minimum Payments

Similarly, title XIX establishes minimum levels for Medicaid payments to at least three kinds of providers. Inpatient hospital care must be paid at reasonable costs, although not necessarily the Medicare definitions of reasonable costs (1902(a)(13)). Effective July 1, 1976, skilled nursing facilities and intermediate care facilities must be paid on a reasonable cost related basis (1902(a)(13)), and regulations are being drafted to implement this rule.

The legislative history reveals a number of reasons why minimum payment standards were introduced:

(a) there was pressure by particular provider groups that minimum payments were essential for the financial viability of these institutions and for their continued operation for all users of services, not just Medicaid recipients;

(b) there were reasons to believe that low rates were jeopardizing the availability for Medicaid patients of care of adequate quality;

(c) special reasons were attributed for the use of reasonable cost or reasonable cost related formulas for establishing the

minimums: (1) cost related formulas would make possible the collection of information and statistical data about the costs and income of institutions; such information was essential for policy decisions. (2) there had been public clamor for radical improvements in the standards of care in certain institutions; it was considered appropriate that the governments assume a major share of the costs that were involved in the improvements of care.

In announcing his intention to introduce legislation which would establish minimum reimbursement rates for physicians serving Medicaid eligibles (80 percent of the comparable Medicare rates), Senator Talmadge pointed to (a) the inequities of Medicaid's current rates; and (b) the resultant low participation rate among physicians.

Regulations

45 CFR 250.30 establishes the conditions whereby each State plan must establish the methods of payment for each type of provider under its Medicaid program.

In addition to the standards of reasonable costs, charges, records, audits, upper limits and lower limits, the regulation states that the State plans must "provide that fee structures will be established which are designed to enlist participation of a sufficient number of providers of services in the program so that eligible persons can receive the medical care and services included in the plan at least to the extent these are available to the general populations."

With the exception of the State systems for reimbursing inpatient hospitals, the Federal government has so far made no effort to assure that the rates paid to providers were compatible with obtaining adequate Medicaid services. In view of the potential Talmadge amendment, and the beliefs that the Medicaid reimbursement rates are impeding participation, the Department should reconsider its position concerning minimum reimbursement rates.

OPTIONS:

Option 1: Establish as a Departmental objective that Medicaid payment rates would be compatible with enlisting reasonable participation of providers (i.e., implementation of 45 CFR 250.30 as cited above). The strategy would vary from the provisions of technical assistance regarding economic and efficient rates to penalties and other sanctions against States for non-compliance.

PRO: Providers would be paid for rendering Medicaid services at rates more competitive with the market. Inequities and sacrifices by providers would be reduced.

Medicaid had been established to remove the financial barriers to obtaining necessary health services. This strategy would be compatible with that objective.

Furthermore, if successful, the strategy would yield adequate participation by providers and appropriate medical care as needed by Medicaid recipients. More economical practices would be adopted. Medicaid would thus be established, not only as a financing program, but as a mechanism for positively affecting the delivery of health care for poor people.

Experience in reimbursing a program of economical and effective reimbursement would be useful for future national health insurance.

Statutory and regulatory authority exist for this program; failure to implement them may be construed as not responsible.

CON: Increases in fees would yield increases in Medicaid costs. To obtain Medicaid physician fees comparable to Medicare, for example, would require additional Federal and State expenditures of more than $300 million.

The increases in fees might not mean increases in the number of participating providers. Factors other than reimbursement rates have been expressed as the reasons for the shortage of Medicaid providers: (1) Providers are frequently concentrated in places outside of the inner city or rural poverty areas (for reasons of the provider's comfort and compatibility); (2) There is a shortage of certain kinds of providers in total, and, therefore, a special shortage of them in the ghettoes; (3) Some providers are reluctant to treat certain races and certain poor people, particularly while health insurance and general affluence assure alternative markets.

Where each of these factors operate, the increased fees would not necessarily mean greater participation; it would mean increased costs and it might mean "windfall profits" for those who would have been willing to participate at the lower rate.

In addition, it would be extremely difficult for the Department to enforce that regulation to assess any violations by the State or to measure the extent of non-compliance. For example, how would we measure to what degree providers were not participating in Medicaid, but available to other purchasers of health services? It would be especially difficult to evaluate whether the non-participation was attributable to the low fee schedules or to other factors; or, a corollary problem, whether raising the fee schedule would yield increases in the number of participating providers.

In addition, the significance of this action is so great that, even though authority exists, current Congressional intent should be clarified. The discussion of the Talmadge amendment might serve that function.

Option 2: Delay more extensive implementation of the regulation, requiring that reimbursement rates be compatible with availability of services, until further research results have been obtained.

PRO: A number of research studies are currently in process. SSA is exploring physician reimbursement rates and the relative availability ofphysicians. OS is exploring the State payment rates for selected frequently performed procedures. The National Academy of Sciences is studying the effect of Medicare and Medicaid reimbursement on the distribution of physicians and specialties in teaching hospitals. SRS is examining reasonable cost related reimbursement and its implications for costs and provider availability in nursing homes.

These studies should yield better understanding of the factors affecting provider participation. A more effective strategy would be developed on the basis of this understanding.

It would be preferable to delay any pressure for increasing Medicaid costs.

CON: Awaiting the results of these studies will probably mean delaying any action for two or three years. The situation is sufficiently critical in some areas (EPSDT, home health, places where emergency hospital rooms are the standard form of Medicaid care), that selected actions could be taken, with confidence that results would be positive.

Furthermore, continued inaction on the part of the Department may stimulate legislation to establish sharply defined Federal payment standards, such as those used in Medicare. (Talmadge Bill is one example.) The results would be similarly inflationary, as well as contrary to traditional Federal/State character of Medicaid.

RECOMMENDATION: Option 2, delay for at least six months the establishment of the objective to have Medicaid rates compatible with enlisting reasonable participation of providers. While the situation is of great importance and urgency, and we should not diminish our efforts to understand the problem, we should avoid precipitate and costly action at this time.

ISSUE: Should the Federal Government encourage the States to engage in fixed-cost contractual arrangements to administer the Medicaid program?

BACKGROUND: In the face of rising program costs and other budgetary pressures, plus adverse criticism of its State administration, North Carolina has contracted with Health Application Systems (HAS), a division of Bergen Brunswig Corporation, to administer its Medicaid program. The two year contract will require HAS to pay for all medical services provided under the North Carolina plan (except prescription drugs), and for all administrative costs. The State retains control over eligibility, State regulations, program content, and the monitoring and evaluation of the contract.

The contractor receives payment from the State of $54.30 per month for each Medicaid eligible up to a maximum of $14.66 million per month. Rates and ceilings are increased by a predetermined amount for the second year of the contract. Thus, the contractor is at risk should medical costs rise, eligibility rise, or utilization rise. If expenditures are less than the State payments, then the State recovers 75 percent of the excess and HAS retains 25 percent.

The determination of the medical necessity for services is made by a subcontractor, North Carolina Medical Peer Review Foundation, created by the State Medical Society.

The advantages to the State in this arrangement are that the State has a fixed cost contract, has transferred the risk to a private contractor, while retaining some of the major policy levers in the program. The contract includes administrative costs, which like medical vendor payments may now be Federally matched at 68 percent. State employee rolls are reduced (and the employees may be able to obtain higher salaries outside the constraints of the State Civil Service system). Furthermore, if the contract is fulfilled, the State will spend less under a privately administrated program than it would have under the State Medicaid agency.

The contractor has the advantage of having one of the first major contracts of this nature, which if successful, could yield others at least as rewarding. He is able to retain 25 percent of the profits resulting from more efficient operations. He may reinsure himself for some of the risk, and in this case, he has reinsured for six million of the $200 million. While he must make many guarantees to the State to fulfill his contract or suffer severe penalties, it is also reasonable to assume that the States will have to bail out the contractor if he suffers disastrous losses. A defunct contract of this magnitude is almost

as untenable as a defunct State Medicaid agency; the State would have to go to the Legislature for appropriate readjustments.

The providers have at least as favorable a position under the contract as with the State Medicaid agency; and if the contractor's claims processing system is as effective as claimed, the providers may have the advantages of more prompt payments. Physicians retain control over the medical practices through the peer review organization.

The recipients are protected by the peer review organization in assuring that only necessary and appropriate care is provided.

On the other hand, there are a number of dangers inherent in the contractual arrangement. The fixed cost contract carries incentives to reduce costs and quality of service, in much the same way that the contracts with PHPs in California did. The State retains the monitoring, evaluation and policy functions to prevent the contractor from engaging in abuses, or failing, through misfeasance, malfeasance or nonfeasance, to fulfill the contract. Nevertheless, the State's powers are limited. In fact, many of the problems of the Medicaid Federal/State partnership (see Issue Paper on Regulations, Compliance and Sanctions) will apply to the Medicaid North Carolina/HAS partnership.

RECOMMENDATION: That the Department develop an independent evaluation of the North Carolina contract. Further activities to encourage similar contracts by other States should await the results of this evaluation.

ISSUE: What has been the Medicaid HMO experience?

BACKGROUND: The number of Medicaid HMOs (and HMO-type prepaid plans), and the number of Medicaid enrollees, reached a peak in late 1974, with approximately 74 plans in 15 States, enrolling upwards of 400,000 Medicaid recipients. Planned enrollment, as indiated by the number of enrollees authorized (approximately 900,000), was much higher.

At the peak, there were 54 plans in California, enrolling about 300,000 Medicaid recipients. After the unfavorable press coverage of abuses in the PHPs, and the Jackson Subcommittee hearings, the number of plans fell to 45, the number of enrollees to 270,000 by June 1975. On June 27, Governor Brown's Administration announced the cancellation of the Governor Reagan created PHP rogram, to be replaced by "Institutes for Medical Services", prepaid plans with tough new standards. It is estimated that the number of plans will be reduced by October to about 16, with the number of enrollees reduced by about half.

In spite of these seeming failures, State officials, HEW staff, and outside experts, consider that HMOs are a viable alternative for Medicaid recipients, with potential for cost effectiveness and improved quality. The Westat study of the GHA Medicaid experiement in Washington, D.C., supported by SRS, has shown significant cost savings and better utilization of preventive care, both characteristics of HMOs. The General Research Corporation evaluation of quality of care in PHPs in California, supported by ASPE, has identified some general lessons and the deficiencies which must be corrected in order to develop HMOs for Medicaid on a solid foundation. These include:

1. Better State monitoring, both for quality of care and cost control, based on objective criteria.

2. Limiting the number of Medicaid enrollees. The plans which had significant numbers of non-Medicaid enrollees gave better care, with greater enrollee satisfaction, and better financial viability.

3. Better control of marketing practices, and greater involvement of the State in the marketing process, in order to find satisfactory alternatives to door-to-door marketing.

The actions SRS has taken and is taking are designed to correct the past deficiencies, and enable the States to put into practice the lessons learned. They include:

1. Stringent final regulations for Medicaid HMO contracting were published May 9, 1975.

2. Guidelines to implement these regulations are in preparation. A first working draft of these guidelines should be ready by the end of July.

3. Technical and actuarial assistance to help States develop their general HMO policies and their rate-setting methods is in progress in nine States. A contractor for the Health Services Administration, the Martin Segal Company, is being used, under the terms of an interagency agreement with SRS.

4. A national workshop on Medicaid HMO contracting, sponsored by SRS in October, 1974, in St. Louis, was attended by Medicaid officials from 43 States. Verbatim proceedings have been disseminated.

5. A proposal by the State of California for an extensive experiment and demonstration, under the authority of Section 222 of P.L. 92-603, is just entering the formal presentation and review process. The proposal is to develop a model State quality assessment and cost control monitoring system, using the surviving California prepaid health plans as a laboratory. Secretary Weinberger has expressed to Senator Jackson and Percy the Department's serious interest in funding such a proposal. The necessity for such a system was the principal conclusion resulting from the March, 1975, hearings on California PHPs conducted by Senator Jackson's Subcommittee on Investigations.

ISSUE: What measures is the Department taking to improve availability of health care services to the Medicaid eligible population in rural areas?

BACKGROUND: There is a growing disparity in rural and urban health care delivery systems, a decreasing number of primary care physicians in rural areas, and inequities in the availability of health care services to the Medicaid eligible population in rural areas.

The Medical Services Administration in close cooperation with the Public Health Service is addressing these problems through a major rural health research and demonstration program.

The aim of these projects is to develop coordinated and coherent areawide health care systems for underserved rural areas. Seven programmatic facets are emphasized:

...preventive health care;
...health education;
...attraction and full utilization of physician extenders;
...attraction and full utilization of medical resources extant in the area;
...methods to attract additional physician manpower;
...finding additional methods that utilize the basic medical funding programs;
...finding new methods of health services delivery.

In addition, these projects bring together at the local level the health care financing expertise of the Medical Services Administration with the health care services delivery expertise of the Public Health Service. This approach combines health services financing and delivery research and demonstration through an innovative organizational arrangement.

STATUS OF PROJECTS: The Medical Services Administration with the Health Underserved Rural Areas (joint SRS/PHS) review committee selected nine projects to be awarded by July 1, 1975, grants totalling $3,298,904. Approximately 17 additional projects will be funded in early fall 1975.

The nine projects are:

		FY75 - Funding Level
Pacific Northwest (2)		
Treasure Valley, Idaho	-	$ 342,760
Yakima Valley, Washington	-	486,350
South (2)		
Gateway, Kentucky	-	401,716
West Virginia	-	465,955
Northeast (2)		
Somerset, Maine	-	345,000
Hanover, New Hampshire	-	360,163
Mountain Plains (1)		
Glendive, Montana	-	174,525
Midwest (1)		
Drayton, North Dakota	-	263,264
Southwest (1)		
Cuba, New Mexico	-	459,171
Total FY75 funding	-	$3,298,904

All of the projects share two characteristics:

1. Part of their overall objectives is coordination of existing sources with other Federal, State or local programs. For example, four projects are establishing regional boards consisting of consumers and providers to direct activities of project.

2. The project is receiving funds or assistance from other Federal programs. For example, 3 projects involve National Health Service Corps physicians directly in the project. Four projects will emphasize the coordination and integration role function and will provide limited primary care with referrals for extensive care. Five projects while also emphasizing the system aspects will provide general primary care and referral for specialists.

The grantees include: 3 private, health agencies; 2 hospitals; 2 medical centers; 1 medical school; 1 district public health agency.

ISSUE: Are there specific problems which have to be addressed and special actions which should be taken because females constitute almost two out of every three recipients of Medicaid services?

BACKGROUND: During FY 1973, the latest year for which reliable data are available, women and girls made up 64 percent of the total number of recipients of Medicaid. The overwhelming imbalance was maintained in each of the major services under Medicaid, and was exaggerated in institutional services and prescription drugs.

TABLE 1

Medicaid Recipients* by Service, by Sex, by percent of Total FY 1973

	Total	Male	Female
Total	100.0	36.1	63.9
Inpatient hospital services	100.0	32.8	67.2
Skilled nursing facilities	100.0	31.7	68.3
ICFs	100.0	35.0	65.0
Physicians services	100.0	35.3	64.7
Dental services	100.0	35.6	64.4
Prescription drugs	100.0	32.1	67.9

*Unpublished data, National Center for Social Statistics

The predominance of benefits for females is even greater in terms of expenditures. Women tend to use the more expensive services and they tend to use these services more frequently and for longer periods than men do.

TABLE 2

Medicaid Expenditures**, by Service by Sex by percent of Total, FY 1973

	Total	Male	Female
Total	100.0	33.3	66.7
Inpatient hospital services	100.0	37.3	63.0
Skilled nursing facilities	100.0	29.7	70.3
Intermediate care facilities	100.0	33.9	66.1
Physicians services	100.0	30.9	69.1
Dental services	100.0	32.6	67.4
Prescription drugs	100.0	27.6	72.6

**Unpublished data, National Center for Social Statistics

Over the years, the proportion of females receiving Medicaid services has continued to increase. But, if even the FY 1973 proportions

were to be applied to the 25 million who are expected to receive Medicaid services in FY 1976, then 9 million men and boys will have been Medicaid recipients compared to 16 million women and girls.

It is significant that 9 percent of the U.S. male population receive Medicaid subsidized services, whereas 15 percent of the U.S. female population receive such services.

TABLE 3

Estimated * Number of Medicaid Recipients, by Sex, FY 1976

	Total	Male	Female
Total	25,000,000	9,000,000	16,000,000
Inpatient hospital services	4,436,000	1,450,000	3,000,000
Skilled nursing facilities	935,000	300,000	640,000
Intermediate care facilities	655,000	230,000	426,000
Physicians services	17,525,000	6,200,000	11,340,000
Dental services	3,642,000	1,300,000	2,340,000
Prescription drugs	15,790,000	5,070,000	10,715,000

* Estimated on the basis of 25 million Medicaid recipients, and the distribution of these recipients by service and by sex, for FY 1973.

It is not surprising that women outnumber men on Medicaid. The cash assistance programs, to which Medicaid is linked tend to have considerably higher proportions of women than men. For example, the 1970 surveys of the cash assistance programs show that 32 percent of those receiving aid to the aged, were male, and 68 percent were female. Since 42 percent of the total population over 65 were male and 58 percent were female, it is clear that females, at least aged women, have lower incomes than their male counterparts.

Fifty-three percent of blind cash assistance recipients and fifty-five percent of disabled cash assistance recipients were female compared to forty-seven percent male blind and forty-five percent male disabled.

This proportion is just slightly different from the proportion of females to males in the total U.S. population, namely fifty-one to forty-nine. Once again, there is confirmation that females, particularly

those with disabling conditions, tend to be poorer than males, or at least are more likely to get cash assistance.

TABLE 4

U.S. Population, by age and sex, by percent of age total, 1970 Census

	Total	Male	Female
Total	100.0	48.7	51.3
Under age 21	100.0	50.9	49.1
Age 21, through 64	100.0	48.3	51.7
Age 65 and over	100.0	42.0	58.0

U.S. Population, by age and sex by percent of U.S. Total 1970 Census

	Total	Male	Female
Total	100.0	48.7	51.3
Under age 21	38.0	19.3	18.7
Age 21 through 64	52.1	25.2	26.9
Age 65 and over	9.9	4.2	5.7

The AFDC program which supplies cash assistance to families with dependent children and only one parent, has been notably dominated by women recipients. According to the 1973 AFDC study, 24 percent of the three million families were headed by men and 76 percent by women.

Figures are not readily available on Medicaid recipients categorized by type of service used, and within each of these classes, by age and by sex. The proportions of Medicaid recipients are so significantly imbalanced, however, compared to the total U.S. population and the poverty population that certain general conclusions are suggested.

Women tend to be poorer (lower earned income and lower annuities), to be sicker, and to use and to need more medical services than men. They tend to provide medical services to members of their own family at no reimbursement, but, they themselves tend to have fewer alternatives to receiving institutional services under Medicaid, are more likely to survive their mates, to be alone and dependent upon society, and to have to accept Medicaid medical support as their only way of receiving medical attention as well as housing and meals.

RECOMMENDATION: The exceedingly large proportion of women receiving Medicaid services, particularly nursing home care, warrants further investigation. There should be an extensive study of the factors which contribute to the high concentration of women among Medicaid recipients.

If some of these factors appear remediable, then attention should be given to the relative costs and benefits of programs directed toward reducing the need of women for Medicaid services -- changes in income support programs, such as changes in Social Security annuities (methods of computing minimums, years of work, lifetime earnings, survivor benefits); health education programs directed towards women and women's medical needs (particularly medical self care); utilization control of certain treatment programs for female disorders (e.g., hysterectomies); social services for women; and community housing programs for senior women. Such studies may contribute substantially to our ability to control the costs of Medicaid as well as to improve the quality of life for many of our citizens.

ISSUE: What role do health education activities have in improving the way in which Medicaid recipients use medical services? What measures should be taken to further those methods of health education which are appropriate to achieving more effective and economical patterns of Medicaid utilization of services?

BACKGROUND: One problem which has been identified in the Medicaid program has been the apparently large proportion of costs which have been devoted to crisis care, to the use of institutional facilities, particularly nursing facilities and emergency hospital facilities, and a correspondingly small proportion of the care, which has been devoted to early prevention and detection of disease. Many authorities contend that health education would make a valuable contribution to more effective utilization of health care resources. A recent (April, 1973) staff report on the Role of Health-Related Supportive Services in the Medicaid Program reported, "The extent to which the poor could be helped to utilize early preventive care could influence a shift in program expenditures toward less costly forms of care for more people, as well as improve the health and self-support and self-care capacity of the disadvantaged. The Community health aide (outreach worker) could play a significant role in the shift if there was opportunity for him to function in a local organizational structure in carrying out functions relating to more effective use of health care resources on an early preventive, as well as continuing care basis; especially in providing health education in relation to the EPSDT program." In essence, health education is considered as a cost-effective means of recruiting the recipient as an active member of the health care team.

A number of activities recently have affirmed the support by the Administration and the Department of Health Education programs, in general. The President's Committee on Health Education made recommendations on September 25, 1973, which resulted in a Departmental Task Force, whose major proposals to the Secretary on May 2, 1974 are in the process of being implemented. The Health Agencies listed Health Education activities as an operating priority; the Department claimed it as a priority for the Forward Plan. Health planning legislation, enacted last year, made health education one of the nine priorities in the formulation of national health policy and in the development and operation of the Federal, State and area health planning and resource development programs.

Further legislation to promote health education activities have been proposed by Rep. Cohen (R., Maine) and Rep. Carter (R., Kentucky).

While there has been support for health education activities as a general concept, there have been only few fragmented efforts to improve health education among Medicaid recipients. These have included: attempts by various HMOs to instruct Medicaid

enrollees on the appropriate use of HMO resources; written notices by States to AFDC recipients on the availability of EPSDT services (a statutory requirement); some States have instituted case-finding and follow-up systems to advise EPSDT recipients of the appropriate next steps to obtain diagnosis and treatment; and there has been some counselling within certain Aging projects (meals-on-wheels, etc.) of the availability of Medicaid services for the needy aged. In general, Medicaid health education activities have been sporadic and have depended upon the accidental and rare existence of someone who was knowledgeable about Medicaid, the health delivery system, health self care, and the needs of Medicaid recipients, who was interested in extending assistance and who had the confidence of the Medicaid recipients.

If it is true that there is improper utilization of Medicaid resources which has resulted in huge wastes of dollars and other scarce resources, and if it is true that Medicaid recipients could learn to use the system more economically, then it would be worthwhile undertaking health education activities as a Medicaid priority. As a minimum, it would be worthwhile presenting the costs and benefits of concerted attempts to improve the understanding by Medicaid recipients of how to care for their health and how to use the health delivery system. A lack of appreciation of any advantages from health education activities in Medicaid has created opposition to them on the part of State officials and even some Departmental officials.

OPTIONS: P

Option 1: Require the States to develop and implement health education programs for Medicaid recipients.

PRO: (1) The States would be most likely to introduce health education programs under a mandated system and so the program cost savings and the improvements in the health of Medicaid recipients would be most likely to be achieved.

(2) Legislative authority exists for establishing such a requirement. In addition to the general authority, Section 1902 (a)(30) which requires State plans to provide methods and procedures as may be necessary to safeguard against unnecessary utilization of care and services, there is a very specific reference in Section 1901 that Medicaid was established to enable States to furnish services to help needy families and individuals attain or retain capability for independence or self-care.

CON: (1) States would object to any increased requirements, which appeared to increase their costs, without sufficient evidence that such activities would be cost-beneficial.

(2) There is little information available on the optimal methods for conducting health education programs for Medicaid recipients.

(3) There is a dearth of individuals qualified to implement health education for Medicaid recipients.

(4) The Department does not have the staff and resources to monitor State activities in this area.

(5) The high turnover in Medicaid eligibles precludes showing benefits from health education activities in the short run.

Option 2: Develop Medicaid health education activities as an operating plan priority for the forthcoming year. During this time, MSA would conduct futher experiments and present the findings of studies which illustrated the costs and benefits of such health education activities, and which developed certain optimal methods and conditions for health education under Medicaid. The year would also be spent in developing a strategy to be used to further those health education methods which were proven cost-beneficial.

PRO: (1) A more reasonable periods of time would be allowed to develop a more viable strategy for furthering health education for Medicaid recipients.

(2) At the same time, the Department would have expressed its commitment to exploring the potentials of health education for more economical and effective health care.

CON: (1) The Department would be committing its limited creative talent to a program whose potential is still controversial.

(2) The Department would appear to be delaying the introduction of health education programs for Medicaid recipients at a time when it is expressing support for these activities for everyone else.

Option 3: Give no higher priority to health education activities under Medicaid than has existed in the past, but continue to support it in such areas where it appears beneficial or required (e.g., EPSDT in Head Start, written notices of EPSDT service availability).

PRO: (1) The Department would be acknowledging its limited confidence in this activity compared to the many higher priority tasks it has to perform.

(2) The Department would be refraining from introducing any new commitments to or requirements for additional expenditures.

CON: (1) The program benefits to be derived from health education would be lost or at least delayed for an extended period. Recipients would continue to mis-use the system, and not sufficiently protect their own health conditions.

(2) The Department would continue to be subject to public and press criticism for its failure to do enough about the excesses of the Medicaid program.

RECOMMENDATION: Option 2 above, which would establish Medicaid health education activities as a priority for the forthcoming year. A small staff would be assigned to explore the potentials of this activity, develop a strategy for the Department, and present their conclusions to the Department, the States, for legislation (if appropriate) and to the public. Part of their charge would be to present recommendations, based on their findings, which would be useful in national health insurance legislation.

Background Papers

Buy-In

Cost Differentials between ICFs and SNFs

Prospective Reimbursement of Hospitals

ISSUE: What modifications of the "buy-in" are desirable?

BACKGROUND: Medicare and Medicaid work in tandem to provide medical assistance for most of America's needy aged and disabled. In FY 1975 Medicaid paid a total of over $4.3 billion in medical assistance for the over 65 population (almost all of whom were Medicare eligible) and over $3.1 billion in medical assistance for the disabled (many of whom were Medicare eligible). This Medicaid assistance was for benefits not covered by the Medicare Part B "buy-in" (e.g. prescription drugs, intermediate care facilities, hospitalization or care in skilled nursing facilities for stays beyond that offered by Medicare) as well as for the deductibles, cost sharing, premiums and other Medicare charges.

A number of statutory provisions of title XIX contain encouragement to the States to provide medical assistance to joint Medicare/Medicaid eligibles:

1. Federal financial assistance (according to the State's medical assistance percentage) is available for covering the deductibles, cost sharing and other charges of receiving services under Medicare part B (1902 (a) (15)).

2. States may provide services in support of Medicare eligibles which they do not provide other recipients (1902 (a) (10)).

3. Federal financial participation is not available under Medicaid for medical assistance for costs which would not have been expended if the individual had been enrolled under Medicare part B (1903(b) (1)).

4. FFP is available for the premiums paid for Medicare-part B coverage for certain cash assistance eligibles (1903(a)(1)). FFP in the buy-in totalled about $100 million in FY 1975.

Forty-eight States and territories have entered into buy-in agreements with the Mecretary, whereby the States pay the premium costs for certain Medicare eligibles enabling them to receive Medicare part B benefits. Twenty-eight, out of the 31 States and territories which cover the medically needy, buy-in for both cash grant and non-cash grant recipients; 20 States (including two of the States with medically needy programs) buy-in for cash grant recipients only. Alaska, Louisiana, Oregon, Puerto Rico and Wyoming have no buy-in agreements. (The period for requesting buy-in agreements has expired, so that legislation would be required to accommodate any State now wishing such an agreement). Some of the States which had no buy-in agreements used to increase the amount of the cash grant by enough to cover the costs of the premiums; presumably they continue to supplement the SSI payments by a similarly sufficient amount.

States which do not have buy-in agreements or which do not buy-in for their non-cash grant Medicaid eligibles claim that costs of paying the premiums would exceed the medical help that would be provided by Medicare. It should be noted that there is no FFP for "buy-in" premiums paid for the medically needy or for other non-cash grant recipients; States must pay 100 percent of these costs. Furthermore, the States claim that they would have to pay premiums for the medically needy for long periods when they would not be Medicaid recipients; medically needy eligibles are difficult to identify when they are not using Medicaid services.

A number of minor problems of record keeping and cost control may arise through the buy-in and the joint funding by Medicare and Medicaid of medical costs for the needy aged and disabled.

1. In principle, FFP is not available for medical services which would have been purchased under Medicare, if the individual had been enrolled. In practice, it is extremely difficult and costly to be sure that all of the Medicare-eligible individuals receiving Medicaid services had, first, been enrolled for Medicare and second, had exhausted their Medicare benefits. The Federal government rarely has the staff to verify the first. Despite the fact that States have a financial interest in transferring as many costs from Medicaid to Medicare as possible, they frequently do not have the management information capability to verify the second and to assure that Medicare pays the first dollar.

2. Since FFP is not available for the buy-in for those who do not receive cash assistance, some States have tried to overcome this condition by manipulating their needs standards and their State supplementation to pay minimal cash grants (e.g., one dollar per month).

It has been proposed that (1) the buy-in be made mandatory, rather than optional, for cash assistance recipients; or (2) the buy-in be made mandatory for <u>all</u> Medicaid-eligible aged and disabled who are eligible for Medicare part B (i.e. cash assistance recipients plus the medically needy); or (3) FFP not be limited to the buy-in for <u>cash</u> assistance recipients, but apply to all coverage groups.

ISSUE: What are the implications of requiring a differential in the payments for SNF and ICF services?

BACKGROUND: As part of the general efforts to control Medicaid costs, a provision (1903(h)) was added by the Social Security Amendments of 1972, which required that there be a differential between the average amount paid in a State (regardless of the source of payment) for inpatient days in skilled nursing facilities versus intermediate care facilities.

A review of the reimbursement rates of 28 States as of March 1974 showed that the law was being implemented, and that there was a differential between the average payments for SNFs and ICFs. On the other hand, since the State Medicaid program was the primary purchaser of services in both of these institutions, this differential in payments could be the result of arbitrary rates set by the State; it could be unrelated to any difference in costs of doing business. In fact, Touche Ross, in a recent study, was unable to show a statistically significant difference in costs between the two types of facilities.

The absence of a difference in costs is not expected. The costs in the two types of institutions depend upon the regulations and the needs of the patients. The SNF patient generally needs more nursing services than an ICF patient. On the other hand, the costs of support services--dietary, laundry, maintenance; and the therapeutic and rehabilitative services in an ICF are usually higher than in a SNF. Furthermore, the capital costs for the ambulatory patient who needs more space, is frequently greater than that needed by a bedfast patient in a SNF.

It is difficult to obtain the data needed for analyzing whether there is a cost differential. There are no current requirements that providers use standard charts of accounts, or that States accumulate provider data using uniform cost reports.

RECOMMENDATION: That the Administration propose the repeal of the requirement of a payment differential for SNFs and ICFs; other methods would be used to control costs in these institutions.

ISSUE: Should State plans be required to provide systems of prospective reimbursement of Medicaid inpatient hospital services?

BACKGROUND: Section 1902(a)(13)(D) and its regulatory counterpart, 45 CFR 250.30 require the States to pay the "reasonable costs" of inpatient hospital services under Medicaid. The principles and standards used to determine such costs must be consistent with those under Medicare. However, as an alternative to Medicare's method of cost reimbursement, States may adopt methods which provide incentives for efficiency and economy, as well as assure adequate hospital participation and availability of high quality services. Three States (New York, Colorado and Massachusetts) have received Departmental approval for an alternative method of reimbursement. Four States (California, South Carolina, Vermont and Maryland) are proposing to use alternative reimbursement methods. All of these alternative methods involve prospective reimbursement for services.

Medicare reimburses inpatient hospital services on a retrospective basis, through a method which has been labeled a "cost pass through system"; all necessary and proper costs in the production of services are reimbursed as they are accrued. The Medicare statute and regulations define the items whose costs are to be passed-through. Payments are made on the basis of estimates of costs (for example, on the basis of last year's costs); at the end of each hospital's fiscal year, costs are audited and final settlements are made.

Cost control has generally been unfavorable, since there is little incentive for hospital management to be efficient or to economize. In fact, Medicare's retrospective reimbursement method has been charged with contributing substantially to the 140 percent increase in hospital costs from the inception of the programs to the beginning of medical care price control. On the other hand, there has been little opposition from the hospitals to this method of payment. Providers of hospital services have the highest participation rate among providers of Medicaid services.

In contrast, a prospective reimbursement system establishes rates in advance and the rates for a unit of service are fixed at the beginning of the contract period (e.g., per hospital day, or per patient stay for a particular diagnosis). Under either the retrospective method or the prospective per diem method, the total amount that a hospital may be reimbursed is not fixed; it may be affected by the number of patients hospitalized, the lengths of their stays, or the use of ancillary services (not included in the per diem rate). To control costs, in addition to utilization reviews, prospective reimbursement systems take advantage of inherent financial incentives. Theoretically, prospective reimbursement methods should restrain the increases in hospital costs, at least for those items included in the prospective rate. The difficulties inherent

in the prospective reimbursement method are the incentives to reduce the quantity and quality of services included in the prospective rate, the hostility of providers and the consequent possibility that services may not be available and accessible to eligibles.

Very few of the State systems have been in place long enough and extensively enough to determine their effectiveness, although preliminary results tend to confirm a priori judgments.

It would be useful to review briefly some of the characteristics of the various State systems.

Massachusetts has already instituted and Californis is proposing to institute a formula system for reimbursing hospitals. The Medicaid rate for each hospital would be set on the basis of its average per diem Medicaid rate in a prior year or years, plus a factor for inflation. In California, the inflation factor would be set State-wide and not subject to exception; Massachusetts accepts appeals by individual hospitals. To encourage hospitals to reduce beds, consolidate facilities or increase occupancy rates, Massachusetts pays on an "adjusted" patient day rather than the actual patient day; i.e., the adjusted figure assumes that the hospital has met a minimum occupancy rate.

In New York State, all third party payors, except Medicare, must propose to and obtain approval from the State Health Cost Commission for their methods of reimbursing for institutional services. Each of the approved methods involves a prospective per diem rate, based on the allowable costs within the hospital and within the peer group in a base period plus an inflation factor, which varies for different geographic areas. The peer groups are composed of hospitals of similar types, geographic areas, facility size and ownership. Hospitals are not reimbursed for costs which exceed 110 percent of the average cost of the hospitals within their peer group; furthermore, the caily rate is based on acceptable minimum occupancy rates. Financing of capital improvements is strictly controlled. Hospitals are allowed to realize savings due to efficiency and economy.

No independent evaluation of the New York system has been completed, although a number are in process. The State maintains that considerable consolidation of facilities has taken place and that the increase in controlled daily rates has been considerably less than the corresponding increase nationwide. The hospitals maintain that there has been a far larger decrease in their revenue than in their costs, that many hospitals are facing insolvency, that innovations and improvements have been deferred or cancelled, and that they are unable to compete for staff with uncontrolled sectors or even hospitals in other States.

Two general criticisms of the New York formulas have been levelled---(1) the formulas favor hospitals which were very inefficient in the base period, and hurt most, those who had improved their management before the system was introduced; and (2) the formulas discourage short intensive care stays and encourage increasing the lengths of stays. (In fact, the average length of stay in New York has increased marginally, while it has decreased in other States.)

In Maryland, the State Health Services Cost Review Commission examines each hospital's operating statistics, and then sets the rates which it may charge for each service. Financing of capital expenditures and "excess capacity" are strictly controlled. The Commission's authority to issue rules which penalize hospitals for inefficient management practices has been challenged successfully in an initial court review.

In Colorado, Vermont, and for certain selected hospitals in South Carolina (under an experiment authorized by Section 222 of PL 92-603) hospitals are required to prepare annual budgets which are approved, before per diem rates may be set. Hospitals have indicated a preference for these budget systems over the formula approaches; since the budgets are initiated by the hospitals, rates tend to be responsive to the conditions which exist in each hospital.

SSA has developed an RFP to analyze the various prospective reimbursement methods. The analysis will include evaluations of: selection, use and projection of inflation indices; methods of analyzing trends and projections of costs; techniques for measuring case mix and volume of admissions; impact of methods on hospital costs, on efficiency, productivity, on admissions rates, lengths of stay, and elimination of non-essential under-utilized services; as well as the administrative simplicity time required to establish rates, negotiation required and the extent of appeals.

OPTIONS: The Department may either require States to establish prospective reimbursement systems or it may continue to leave to the States the choice of whether to introduce such systems.

Option 1: The Department should issue a regulation which requires States to develop and operate an approved system of prospective reimbursement for inpatient hospital services under Medicaid.

PRO: (1) Prospective reimbursement would provide incentives for efficiency and economy. The rate of increase in hospital costs would be reduced. Hospital expenditures would be more predictable. Pooling of facilities would take place; unnecessary beds and inherent pressure for higher rates would be reduced.

(2) A Federal requirement would make it easier for the States to introduce prospective reimbursement and to resist the opposition to it from local hospital associations.

(3) The Secretary already has statutory authority to introduce such a regulation, since 1902(a)(13) empowers him to establish regulations concerning reimbursement for reasonable costs of inpatient hospital services under Medicaid; 1861(v) states that reasonable costs may be based on factors compatible with efficient and economical delivery of services.

CON: (1) It has not been rigorously demonstrated that prospective reimbursement inevitably leads to economical and efficient operation. For example, nursing homes are generally paid of a prospective rate basis; there have been numerous complaints concerning the effectiveness of nursing home services.

Furthermore, prospective per diem rates provide incentives for increased lengths of stay, for admitting patients who require less intensive care, and for increasing ancillary services.

(2) Fixed rates tend to encourage the deferral of investment and expenditures; tend to reduce the ability of hospitals to compete with other sectors of the economy for necessary skilled personnel; and tend to provide disincentives for improvement in quantity and quality of services. If these rates are applied only to services for Medicaid eligibles, then there will be fewer services available to Medicaid eligibles.

(3) Regulating the States or the hospitals may be imposing burdens on institutions who have little or no control over the factors of costs. First of all, physicians and not hospitals generally determine admissions and courses of treatment. Secondly, hospital labor costs have traditionally been depressed; wages will have to be adjusted to make them more competitive. Such adjustments would not be possible if rates are pegged to past levels.

(4) There would be considerable opposition to such a Federal regulation, along with contentions that the statute does not explicitly empower the Secretary to require such methods.

Option 2: States would retain the choice of whether to adopt prospective reimbursement systems. The Department would defer mandating prospective reimbursement until there have been more definitive results from the various State programs. The Department would publicize exemplary practices and provide the States with assistance in adapting these practices to their State programs.

PRO: (1) Insofar as States voluntarily adopted prospective reimbursement systems, this option would have the advantages listed for the option above.

(2) The controversy would be reduced, since the requirement to introduce prospective systems would be deferred until there was more evidence of their usefulness and until there was less opposition to them.

CON: Might delay indefinitely the introduction of prospective reimbursement, particularly in States where there was considerable local opposition.

RECOMMENDATION: Option 2 - Permit the States the choice of whether to introduce prospective reimbursement systems. Defer mandating such systems until further evidence was available.

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